EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE REGARDING RISK FACTORS AND PREVENTION OF PEPTIC ULCER AMONG MIDDLE AGE POPULATION IN CO-OPERATIVE SUGAR MILL AT CHEYYAR TALUK.

BY

MS.SIVAGAMI .T

A Dissertation submitted to
THE TAMIL NADU DR. M.G.R. MEDICAL UNIVERSITY,
CHENNAI

IN PARTIAL FULFILMENT OF THE REQUIREMENT
FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING.

APRIL- 2012.

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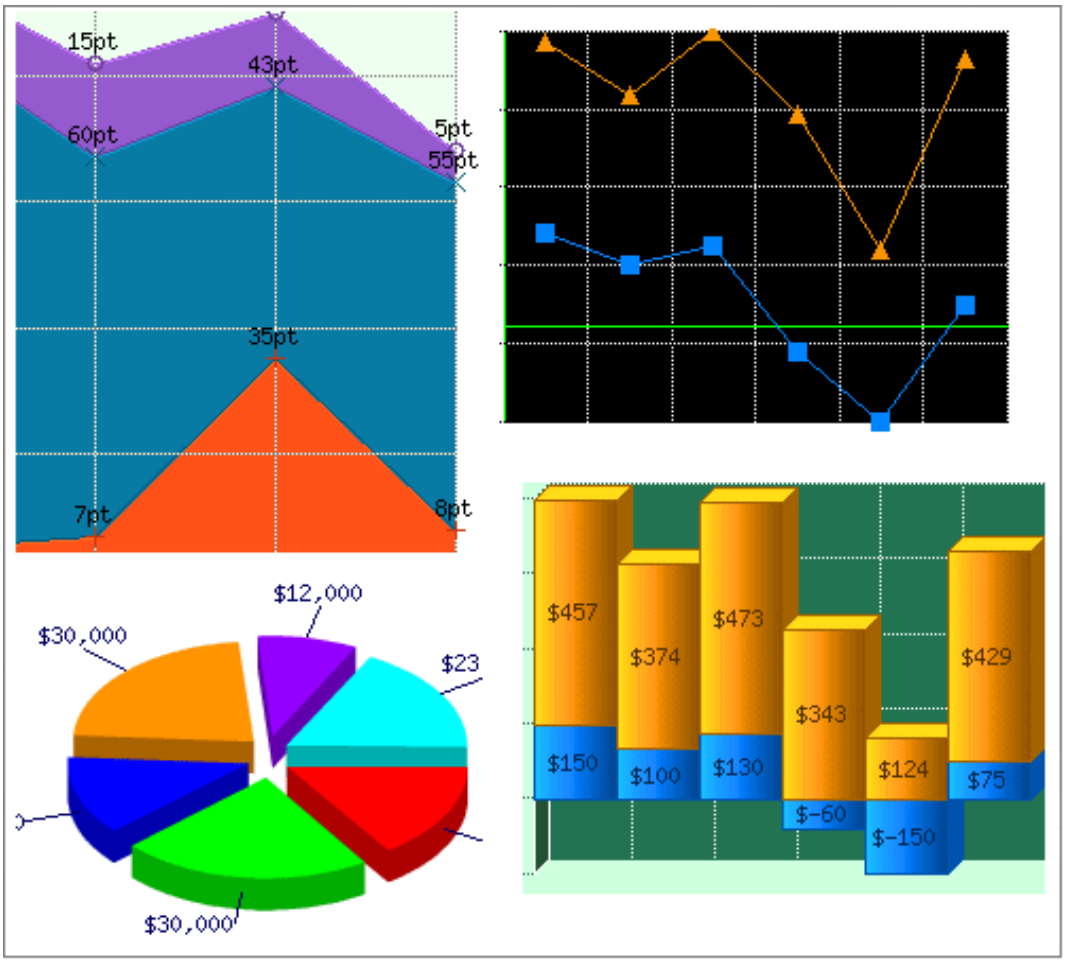

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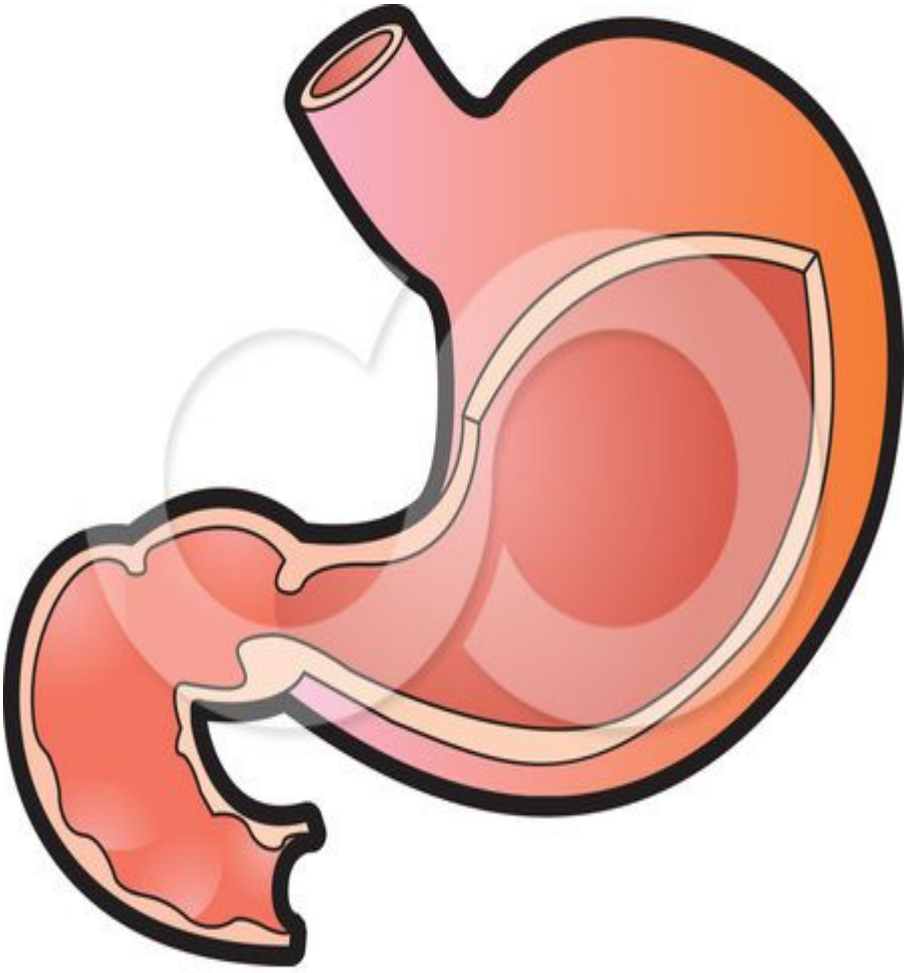
CHAPTER – I

INTRODUCTION



CHAPTER- I

INTRODUCTION

“Everything in excess is opposed to nature”

The stomach is an enlarged segment of the digestive tract in the left superior part of the abdomen. Its shape and size vary from person to person even with in the same individual its size and shape will change from time to time depending on its food content and the posture of the body.

Disease of the stomach is common and cause significant morbidity, economic hardships and health consequences. Acid peptic ulcer diseases alone has accounted for an estimated $12.4 billion in direct costs in 2009.

The term peptic ulcer disease generally refers to spectrum of disorders that includes gastric ulcers, pyloric ulcer, duodenal ulcer and post operative ulcers at or near the site of surgical anastomosis.

Pathologically the definition of a peptic ulcer is straight forward it is a defect in the gastric or duodenal wall that extends through the muscular is mucosa (the lower most limit of the mucosa into the deeper layers of the wall sub-mucosa or the mascularis propria). It is with in these layers, in that the ulcer may erode a major blood vessel to produce the complication of potentially life- threatening hemorrhage.

Peptic ulcer disease is a condition characterized by erosion of the Gastro Intestinal mucosa resulting from the digestive action of hydrochloric acid and pepsin. Any portion of the gastro intestinal tract that comes into contact with gastric secretions is susceptible to ulcer development including the lower esophagus, stomach duodenum, and margin of gastrojejunal anastomosis after surgical procedures. There are approximately 500,000 new cases of ulcers diagnosed and over 4 million recurrences of peptic ulcer each year.

Perforation of peptic ulcer usually presented as an acute-abdomen. Initial symptoms of perforated duodenal or gastric ulcer, includes a severe and sudden onset abdominal pain that

is worse in right upper quadrant and epigastria and usually accompanied by vomiting and nausea. There is rapid generalization of pain and examination shows peritonitis with lack of bowel sounds. In one lack population 10% of cases has got an associated episode of melena. Perforated peptic ulcer is more common in elderly patients prone for higher use of non-steroidal anti-inflammatory drugs also dies to ambiguous signs of the disease and there would be a delay in diagnosis. Elderly patients are likely to have other medical problems which increase the rate of morbidity and mortality in this group.

There are some measures to decrease the risk of peptic ulcer disease and perforation since about 30% of patients with perforated peptic ulcer are taking non-steroidal anti-inflammatory drugs. Use of these drugs should be lessened or at least use concomitant anti-ulcer medications smoking cessation and abstinence from alcohol should also increase the risk of complicated peptic ulcer. Early diagnosis and treatment of peptic ulcer have important role in prevention of complication.

In June 2010, Omnicare an independent long term case pharmacy and consulting, released the first edition of the Geriatric pharmaceutical care guidelines, geriatric, specific, clinically driven formulator evaluating medications by disease indication. Clinical evaluation of each drug category was performed by an independent, The Philadelphia college of pharmacy and Sciences, in evaluating, equally effective for the treatment of peptic ulcer disease.

Diseases of the stomach are common and cause significant morbidity, mortality. A study conducted on Factors affecting mortality and morbidity in patients with peptic ulcer perforation was done by Ankara Numune Training and Research Hospital, Turkey in the year of 2010 April. The records of 269 patients who had been operated for perforated Peptic Ulcer had been reviewed retrospectively. The following factors had been analyzed in terms of morbidity and mortality: age > 65 years; gender associated medical illness; chronic ingestion of non-steroidal anti-inflammatory drugs, aspirin, corticosteroids or immune-suppressants; alcohol ingestion and smoking habits; American Society of Anesthesiologist status;

season; delayed operation; site of ulcer perforation; and shock on admission and type of operation.

There were 30 female (11.16%) and 239 male (8.84%) patients. Seventy-one (26.4%) patients had associated diseases. Simple closure was performed in 257 (95.5%) patients; 12 patients (4.5%) underwent definitive operations. A total of 108 postoperative complications were present in 65 (24.2%) patients. Twenty-three patients died (8.55%). Multivariate analysis showed that only age, treatment delay, presence of shock and definitive operation were independent predictors of mortality.

Significant risk factors that led to morbidity were time of surgery, season, presence of shocks and type of surgery. There was a significant difference concerning morbidity and mortality between simple closure of the perforation and definitive surgery. Age, delayed surgery, presence of shock and definitive surgery are the factors significantly associated with fatal outcomes in patients undergoing emergency surgery for perforated Peptic Ulcer. Therefore, proper resuscitation

from shock, decreasing delay and reserving definitive surgery for selected patients is needed to improve overall results.

Our understanding of the etiology and pathogenesis and our approach to treatment have undergone remarkable changes in the last 30 years. Up to the early 2005, peptic ulcer was seen as a disease of excessive gastric acid production and its treatment primarily surgical.

NEED FOR THE STUDY

Peptic ulcer is the primarily reported cause of death in approximately 6500 persons in the United States each year. The estimated direct costs of patient care and indirect costs caused by work and productivity loss for peptic ulcer are $6 billion annually. Before 2000 the major causes of peptic ulcer had been considered to be excess acid, diet, smoking and stress.

Peptic ulcer, 60% of respondents believed that ulcers had caused by too much stress 17% believed that eating spicy foods caused ulcers and 27% believed that a bacterial

infection caused ulcers. The belief that stress was the highest among cause persons aged 18-24 years and among persons with annual household incomes of less than $15,000.

According to World Health Organization (WHO), peptic ulcer is fifth only to cardiovascular disease as a global healthcare problem and medical studies show a 50-year-old woman has a similar lifetime risk of dying from Peptic ulcer as from breast cancer. Since peptic ulcer affects the elderly population which is growing, it will put a bigger burden to the healthcare system as treatment is expensive. Unless swift action is taken, it can escalate into an economic threat.

In the United States there are approximately 100,000 new cases and 4 million recurrences of peptic ulcer disease yearly. The one-year point prevalence of peptic ulcer in the United States is about 1.8% of a life time prevalence of 8-14%. Estimated annual direct costs for peptic ulcer disease are $3.3 billion with additional costs of 6.2 billion.

Peptic ulcer disease due to H. pylori is unlikely to have its initial presentation at age ≥50 years. In Western countries H. pylori infects about 20% persons below the age of 40 years

and 50% of persons above the age of 60 years. The incidence of H. pylori infection in developing countries is much higher.

A study on Canonical correlation analysis of factors involved in the occurrence of Peptic Ulcers has been conducted by Faith University, Faculty of Science and Literature, Department of Mathematics, Istanbul, Turkey in the year of 2007 January. The impact of risk factors on the development of peptic ulcers has been shown vary among different populations. We sought to establish a correlation between these factors and their involvement in the occurrence of peptic ulcers for which a canonical correlation analysis was applied. It included 7,014 patient records (48.6% women, 18.4% duodenal ulcer, 4.6% gastric ulcer) of those underwent upper gastro-endoscopy for the last 5 years. The variables measured are endoscopic findings (duodenal ulcer, gastric ulcer, antral gastritis, erosive gastritis, pangastritis, pyloric deformity, bulbar deformity, bleeding, atrophy, Barrette esophagus and gastric polyp) and risk factors (age, gender, Helicobacter pylori infection, smoking, alcohol, and non-steroidal anti-inflammatory drugs and aspirin intake). It is

found that duodenal ulcer had significant positive correlation with bulbar deformity, pyloric deformity, gender, H. pylori, bleeding, smoking, aspirin use, alcohol intake, and non-steroidal anti-inflammatory drugs. Gastric ulcer had a significantly positive correlation with pyloric deformity, age, bleeding, gender aspirin use, bulbar deformity, alcohol intake, smoking, and Barrette esophagus. The level of significance was much higher in some variables with duodenal ulcer than with gastric ulcer and the correlations with gastric ulcer in spite of being highly significant the majority, were small in magnitude. In conclusion, Turkish patients with the following endoscopic findings bulbar deformity and pyloric deformity are high-risk patients for peptic ulcers with the risk of the occurrence of duodenal ulcer being higher than that of gastric ulcer. Factors such as H.pylori, smoking, alcohol use, and non-steroidal anti-inflammatory drugs use are risk factors that have significant impact on the occurrence of duodenal ulcer; aspirin has a significant impact on both duodenal ulcer and gastric ulcer.

The last 20 years of study have uncovered the complicated relationship between humans and this organism in terms of transmission physiologic consequences of infection and subsequent disease states. A particularly thorough review of the patho-physiology of H. pylori infection has recently been published while the majority of infected persons remain asymptomatic 10-15% will develop peptic ulcer disease.

In the developing world 80% of the population shows evidence of infection compared to only 35-40% in the industrialized world. The prevalence of infection is even smaller in younger cohorts in the developed world.

In India, Helicobacter Pylori infection is common. Exposure occurs in childhood and approximately 80% of adults have been infected at same time.

The environment in India is contaminated and gastro intestinal infections, symptomatic and asymptomatic are very common.

Second rates of recurrence of H. pylori infection may be expected to be high in India H. pylori – re infection rates are very low in Western populations. Being less than 0.5 per patient year, in one Indian study of 45 patients following eradication of H. pylori, recurrence of infection was detected in only one patient (24%) after one year. However a rigorous search was not performed to detect recurrent infection. The only other full publication on re-infection in the Indian literature suggests that recurrence of infections occurs in around 60% of patient infection with the organism is most common in population with poor sanitary and hygiene condition.

Both the incidence of and mortality from bleeding and perforated peptic ulcers are growing. It is assessed the association between smoking, ingestion of alcohol (including the type of alcoholic beverage), and risk of a complicated peptic ulcer in a population-based study of 26,518 Danish subjects followed up for an average of 13.4 years. There were 214 cases of incident bleeding and 107 cases with perforated ulcers. It is estimated the relative risks of incident bleeding

and perforated peptic ulcer with the Poisson regression analysis. Smoking more than 15 cigarettes a day compared with never smoking increased the risk of a perforated ulcer more than threefold 95% confidence interval. Ingestion of more than 42 drinks a week increased the risk of a bleeding ulcer fourfold compared with ingestion of less than one drink a week. Comparison of the same group, showed that subjects who ingested more than 21 drinks a week, but no wine, were at a higher risk of a bleeding ulcer 95% than drinkers of the same amount of alcohol, but with more than 25% of their intake as wine.

In Tamil nadu, one in ever ten an ulcer at some point in life peptic ulcer disease affects all age groups including children. Men are affected twice as often as women.

Acid peptic disorders, particularly gastric and duodenal ulcer are common in elderly long-term care residents. They are associated with substantial, negative outcomes, including increased morbidity, hospitalization and even death. As a subgroup of acid peptic disorders peptic ulcer disease is especially problematic in the elderly population as these

patients may exhibit difference in the clinical presentation of the disease as well as increased bleeding and mortality rates, compared with young individuals.

Those practicing in the long term care setting are finding that the incidence of peptic ulcer disease has increased in elderly women. In this study 77% of participant nursing home data showing that 67% of residents are women.

Peptic ulcer disease was once thought to be caused by stress, spicy food and alcohol & the treatment was bed rest and a bland diet. The role of stomach acid was then discovered and antacids were introduced into the therapeutic regimen.

STATEMENT OF THE PROBLEM

A STUDY TO ASSESS THE EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME (STP) ON KNOWLEDGE REGARDING RISK FACTORS AND PREVENTION OF PEPTIC ULCER AMONG MIDDLE AGE POPULATION IN CO-OPERATIVE SUGAR FACTORY AT CHEYYAR TALUK.

OBJECTIVES OF THE STUDY

1) to assess the existing knowledge on risk factors and prevention of peptic ulcer among middle age population in co operative sugar factory at Cheyyar taluk.

2) to determine the effectiveness of structured teaching program on risk factors and prevention of peptic ulcer among middle age population in co operative sugar factory at Cheyyar taluk.

3) to find out the association between post test knowledge level with their selected demographic variables.

HYPOTHESIS

H1: There is a significant difference between pre-test and post test knowledge of Risk factors and prevention of peptic ulcer.

H2: There is a significant association between knowledge of Risk factors and Prevention of peptic ulcer with selected demographic variables.

ASSUMPTION

- Clients have inadequate knowledge on risk factors and prevention of peptic ulcer.
- Structured teaching programme will enhance the knowledge of risk factors and prevention of peptic ulcer.
- This will help them to apply the knowledge in life.

OPERATIONAL DEFINITIONS

ASSESS

It refers to the evaluation of the level of knowledge regarding risk factors and prevention of peptic ulcer.

EFFECTIVENESS

It refers to a significant increased level of knowledge of the patients after teaching programme.

STRUCTURED TEACHING PROGRAMME

It refers to a system of planned instructional design to impart information in order to bring a change in knowledge regarding risk factors and prevention of peptic ulcer.

RISK FACTORS

It refers to predisposing factors like H. Pylori infection, Use non-steroidal anti inflammatory drugs, Smoke cigarettes, Drink alcohol, and stress and Spicy foods leading to peptic ulcer.

PREVENTION

It refers to measures adopted by the subjects to prevent peptic ulcer.

MIDDLE AGE

Those who are between the age group 30 and 45 years.

LIMITATIONS

1. The study was limited period of 6 weeks only.
2. The study was not generalized.
3. The study was conducted in selected industry.

DELIMITATIONS

1. The study was only for the middle age clients between 30 and 45 years
2. Samples has been selected by simple random sampling method
3. Data was collected through questionnaire

CONCEPTUAL FRAME WORK

Conceptual models are made up of concepts, which are words describing mental images of phenomena and prepositions. General systems theory developed by **ALBWIGN VON BETTANLAFFY** offers a prospective looking at man and nature as interacting wholes with integrated sets of properties relationships

All living systems which are open to the systems are open to the exchange of matter and to the information. The investigator used the model based on these theories

INPUT

A system imparts products known as input in this study after assessing the existing knowledge; the investigator has given structured teaching programme regarding risk factors and prevention of peptic ulcer in the input process.

THROUGHPUT

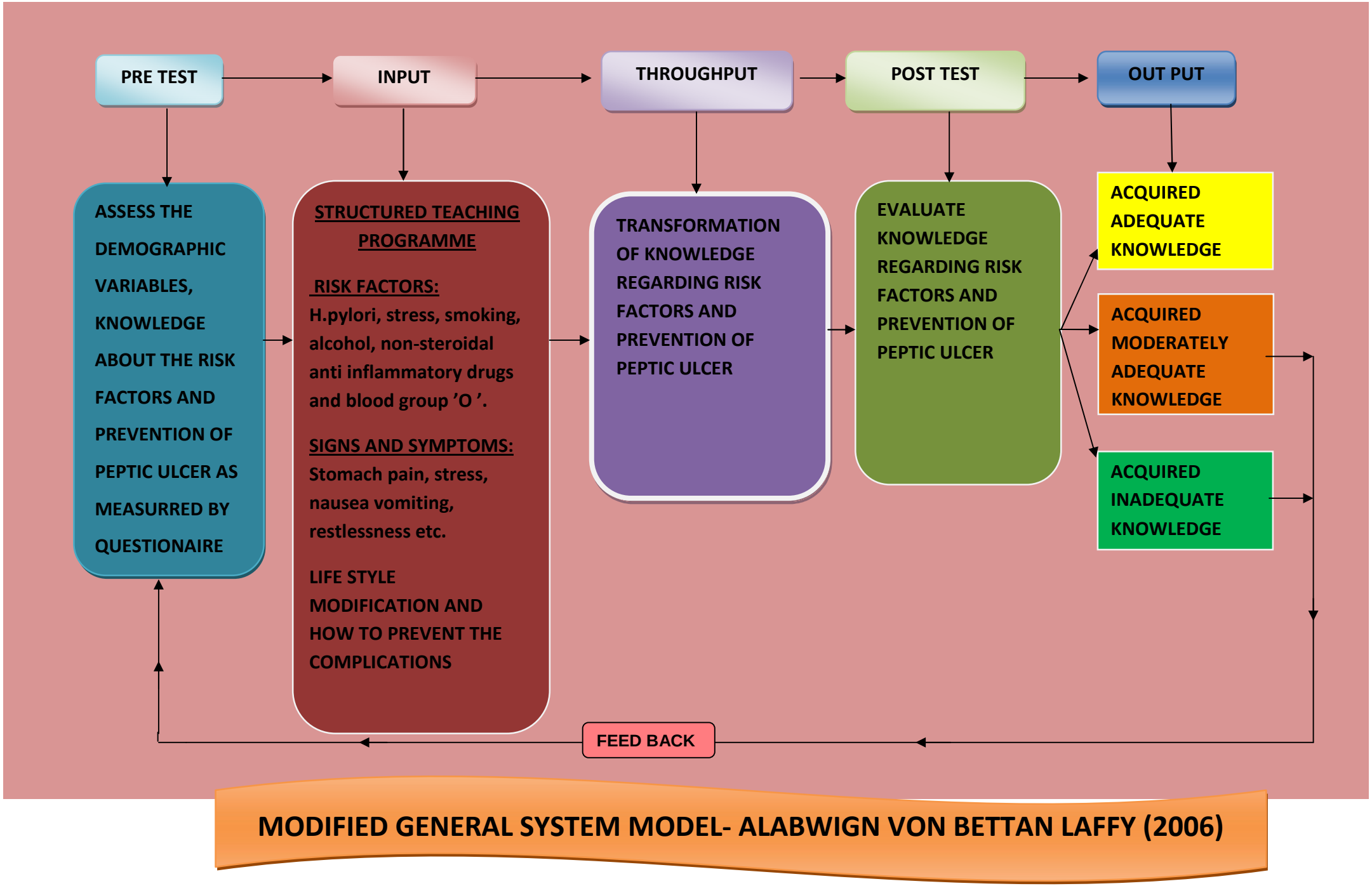
A system transforms, creates and organizes the process known as throughput which results in a reorganization of the input that is after a structured teaching programme there is a change taking place in the subject regarding risk factors and prevention of peptic ulcer.

OUTPUT

A system expert views in a process known as output. Is a product given of outside the system which can be detected and related to the system. This output is mentioned as post teaching stage in this study. This stage encompasses the improved adequate knowledge related to risk factors and prevention of peptic ulcer.

FEEDBACK

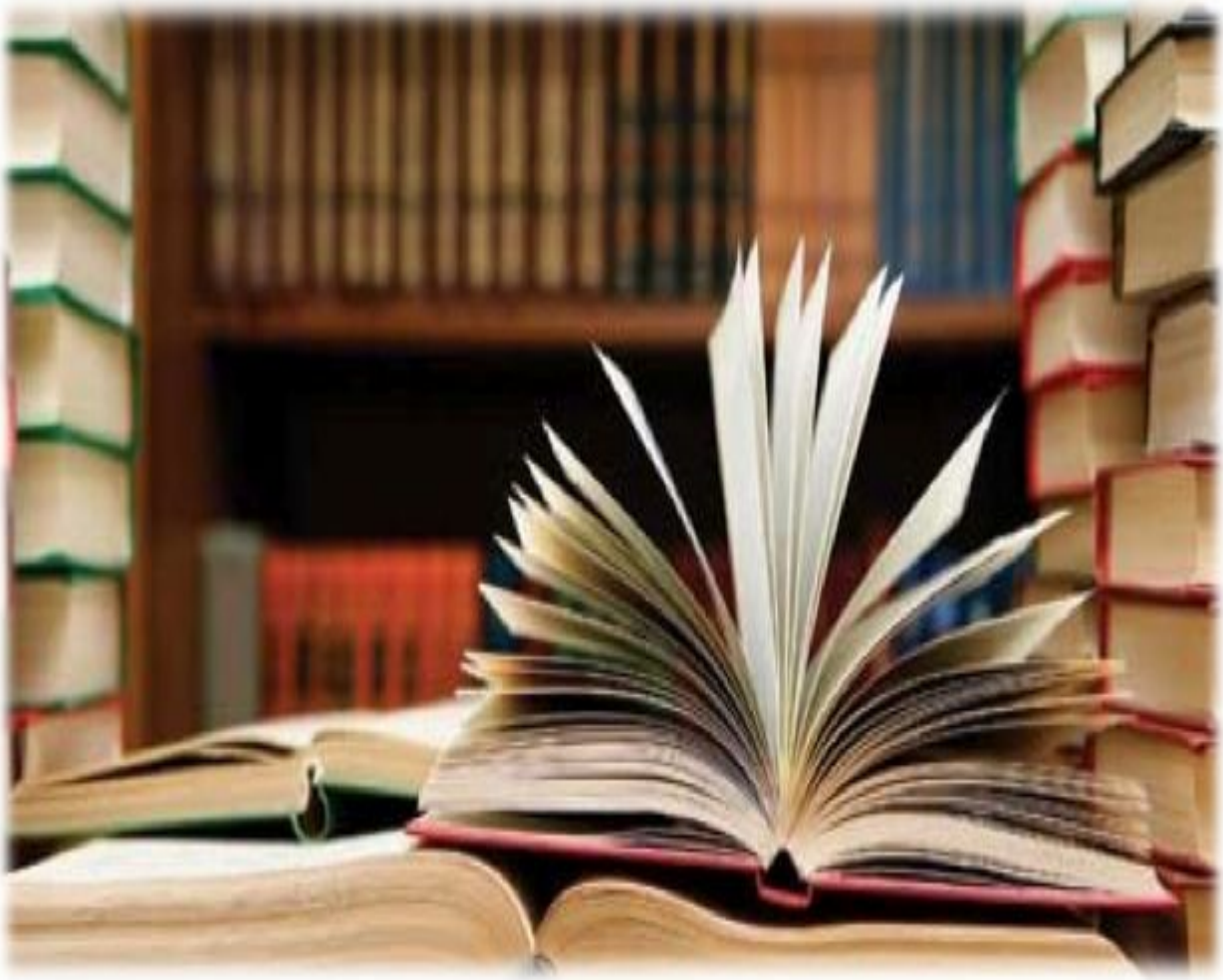
The feedback is the environmental response of the system. Feedback may be positive or negative or neutral. Feedback encompasses to strengthen the input and throughput. It is necessary if the result showes any inadequate knowledge.



MODIFIED GENERAL SYSTEM MODEL- ALABWIGN VON BETTAN LAFFY (2006)

CHAPTER – II

REVIEW OF LITERATURE



CHAPTER- II

LITERATURE REVIEW

The review of literature is an extensive, systematic selection of potential sources of previous work, facts and findings of the chosen problem. It is a body of text that aims to review the critical points of current knowledge including substantive findings as well as theoretical and methodological contributions to a particular topic.

This chapter deals with review of literature which helps in integrating diverse opinion on the study and is an essential component of research problem. The investigator carried out extensive review of literature relevant to the research topic to gain insight and to collect information for this study.

The review of literature related to this study has been discussed under following headings

PART: I Studies related to the knowledge regarding peptic ulcer.

PART: II Studies related to causes / risk factors of peptic ulcer.

PART: III Studies related to prevention of peptic ulcer.

PART:I STUDIES RELATED TO THE KNOWLEDGE REGARDING PEPTIC ULCER

Riccio.et.al., (2011),suggest that a very early upper endoscopy was performed to find the source of upper gastrointestinal bleeding and to take biopsy specimens for analysis of H. pylori infection by the rapid urease test.

Milosavljevic.et.al., **(2011),** concluded that there is important time trends embedded within this stable overall rate of complications the dramatic decline in the prevalence of Helicobacter pylori an increased use of nonsteroidal anti-inflammatory drugs and an increased rate of ulcer complications related to such drug use, especially in the elderly.

Tytgat.et.,al., (2011), suggests that Ulcers never develop spontaneously in a healthy gastro duodenal mucosa. The dominant aggressors are strong acid and high proteolytic (pepsin) activity in gastric secretions. The longer the intragastric pH was >3, the quicker ulcer healing was seen.

Banic.et.al., (2011), concluded that Antacids, Protective agents, anticholinergics, and later gastric antagonists and Prostaglandins were used for decades in the treatment of peptic ulcer.

ZebrowskaMet., al., **(2011),** concluded that Polymorphism may also be associated with an increased likelihood of H. pylori infection development, especially in women.

Critchleyet., et., al., **(2011**), suggests that Laparoscopic surgery has become increasingly popular for elective surgery.But it has gained slow transference to emergency surgery. Laparoscopic and open repair are equally safe in the management of Perforated Peptic Ulcer (PPU).

Ermiset., et., al., **(2010),** suggests that Second-line levofloxacin-based triple therapy's efficiency for Helicobacter pylori eradication in patients with peptic ulcer.

Milosavljevic T.,et., al., **(2010),** suggests that there are four major complications of peptic ulcer disease (PUD)bleeding,perforation, penetration, and obstruction.

Hunt RH,et., al., **(2010),** states that the presence of gastric acid plays a critical role in the mechanisms of NSAIDs/aspirin-associated gastric and duodenal mucosal injury and ulceration. The role of gastric acid and its relationship to aspirin in mucosal damage, ulcer and ulcer complications continues to be an important concern because of the

increasing worldwide use of Non steroidal anti inflammatory drugs and aspirin.

Malfertheiner P. et., al., **(2010),** state that gastritis and corpus atrophy are accompanied by hypochlorhydria and carry the highest risk for gastric cancer, whereas antrum-predominant gastritis with little involvement of the corpus-fundic mucosa is associated with hyperchlorhydria and predisposes to duodenal ulcer disease.

Vale FF. et., al., **(2010),** suggests that Helicobacter pylori is a common human pathogen infecting about 30% of children and 60% of adults worldwide and is responsible for diseases such as gastritis, peptic ulcer and gastric cancer.

AhmetKaraman., et., al., **(2010),** states that argon plasma coagulation an effective hemostatic method in bleeding peptic ulcers. Larger multicenter trials are necessary to confirm these results.

Ding J, et., al., (2010), Laparoscopic repair of perforated peptic ulcer is associated with improved outcomes in terms of less blood loss, quicker recovery, and lower rates of wound infection and mortality. Laparoscopic repair of perforated peptic ulcer is safe and feasible.

Roberto Manfredini., (2010), states that a seasonal variation in Peptic ulcer disease, characterized by three peaks of higher incidence

in autumn, winter, and spring is observed and confirmed as higher risk periods.

Goldie L et., al., (2010), concluded that Millions of Americans suffers from peptic ulcer disease. With approximately 10% of the U.S. population experiencing this condition, it has significantly impacted our health care system. The prevalence within the United States has become equal for both men and women. Death rates over the last 50 years have declined for Peptic ulcer diseases, primarily due to decreases in men.

Reimar W. Thomsen et., al., (2010), concluded that Diabetes may influence the outcome of complicated peptic ulcer disease, due to angiopathy, blurring of symptoms, and increased risk of sepsis.

Colin W. Howden, et., al., (2010), suggests that The familial accumulation of peptic ulcer disease observed in several studies may be attributable to genetic effects, aggregation of environmental exposure (shared environment), or both. The intrafamilial spread of Helicobacter pylori infection has raised the question whether shared environment could explain the familial aggregation of peptic ulcer disease rather than genetic similarity of family members.

Grigoris I. Leontiadis,et., al., (2010), concluded that in ulcer bleeding, Proton Pump Inhiiibitors reduce rebleeding and the need for

surgery and repeated endoscopic treatment and improve mortality among patients at highest risk.

ZhurnalNevropatologii et., al., (2010), concluded that the use of laser puncture in multimodality therapy of peptic ulcer patients favors correction of vegetative disorders and normalization of regenerative processes occurring in the gastro duodenal system.

Mitsuru et., al., (2010), suggest that not only physical but also psychological stress is still an important pathogenic factor for peptic ulceration and accordingly that physicians should pay attention to the possible presence of psychological stress in the management of patients with peptic ulcers.

Ching-Liang et., al., (2010), suggests that silent peptic ulcer disease is common in Taiwan. Dyspeptic symptoms because of peptic ulcer disease may be influenced by intrinsic (body mass index and ulcer characters) and extrinsic (habitual tea drinking) factors. Non-steroidal anti-inflammatory drug use and *Helicobacter pylori* status had no significant effect on the symptomatology of peptic ulcer disease.

Takahisa Suzuki et., al., (2010),,states that Cerebral air embolism is a rare complication of penetrating gastric ulcer, but should be considered in patients with a history of esophagectomy with gastric conduit that present with acute neurologic findings.

Dzhitava IG, et., al., (2010), states that Algorithm diagnosis and treatment of acute ulcers by different groups of patients.Treatment depends on the nature of secretoryactivity stomach bleeding risk of relapse and localization ulcers.

Sarkeshikian SS et., al., (2010), Concluded that gastrinoma as the etiology of peptic ulcer disease, accumulation of peptic ulcer disease complications is highly suggestive of Zollinger-Ellisone syndrome (ZES).

Uruha A et., al., (2010), states that Wernicke's encephalopathy (WE) whose only prior illness was peptic ulcer disease. Wernicke's encephalopathy (WE) there is the possibility that peptic ulcer disease itself provoked thiamine deficiency due to malabsorption.

Chun–Peng Liu et., al., (2010), states that patients with atherosclerosis and a history of peptic ulcers, the combination of esomeprazole and clopidogrel reduced recurrence of peptic ulcers, compared with clopidogrel alone. Esomeprazole does not influence the action of clopidogrel on platelet aggregation.

PART:II STUDIES RELATED TO RISK FACTORS/CAUSES OF PEPTIC ULCER

Chiu et. al., (**2011**), suggests that nonsteroidal anti-inflammatory drugs (NSAIDs) can have severe effects on the

entire gastrointestinal tract, including bleeding, perforation and occlusion.

Chan, et., al., (2011), suggests that high-dose intravenous omeprazoleafter endoscopic therapy in high-risk patients with acute peptic ulcer bleeding.

Ozdil et. al., (**2011)**, concluded that Atherosclerosis and acetylsalicylic acid are independent risk factors for hemorrhage in patients with gastric or duodenal ulcer.

Gorgieva et., al., (2011),concluded that Infection with Helicobacter pylori increases the risk for peptic ulcer disease and its complications.

Chen et., al., **(2010),** concluded that the general population, patients with end-stage renal disease (ESRD) have increased peptic ulcer and upper GI bleeding complication rates.

Kang JM et., al., (2010),states that Helicobacter pylori, nonsteroidal anti-inflammatory drugs (NSAIDs), and antiplatelet agents in the risk of peptic ulcer bleeding has not yet been established. This study was performed to identify the risk factors for peptic ulcer bleeding compared with non-bleeding peptic ulcer disease (PUD).

Sostres C,et., al., **(2010),**suggest that Aspirin is being used as an effective analgesic and anti-inflammatory agent at doses >325 mg daily. At low doses (75-325 mg daily), aspirin is the key antiplatelet drug in the pharmacological prevention of cardiovascular diseases. Topical and systemic effects of aspirin in the gastrointestinal mucosa are associated with mucosal damage in the upper and lower gastrointestinal tract.

Bode G, et., al., **(2010),**suggest that assess the relation of smoking and alcohol and coffee consumption to active Helicobacter pylori infection. These results suggest a protective effect of alcohol consumption against active infection with H pylori and an opposite effect of coffee consumption

D H Hull et., al., (2010), concluded that continued cigarette smoking does not prevent the powerful duodenal ulcer healing effect of cimetidine but does predispose to an increased expectation of duodenal ulceration soon after cimetidine has been stopped.

ying bio et., al., (2010), concluded that Gastric ulcer increases the risk of pancreatic cancer, whereas there does not appear to be an association between duodenal ulcers and pancreatic cancer.

Shiotani et., al., (2010), states that association between peptic ulcer and angiotensin type 1 receptor blockers reductive inhibitors. Significantly associated with peptic ulcer haplotype may identify patients at increased risk for aspirin-induced peptic ulcer

Ikuko Kato et., al., **(2010),** suggests that the risk of both gastric and duodenal ulcers progressively increased with increasing pack-years of cigarette smoking. In contrast, alcohol intake was not associated with either type of ulcer. The risk of gastric ulcer was positively associated with the use of table salt/soy sauce, but there was no association with the consumption of other oriental foods.

Patricia Chou et., al., (2010), suggests that Excessive alcohol consumption causes damages to the stomach or duodenum by impairing the integrity of the mucosal barrier. indicated that alcohol consumption only minimally increased the ethanol intake odds of peptic ulcer.

Talley**, et., al., (2010),** concluded that Mood or anxiety disorders are associated with increased rates of peptic ulcer disease; nicotine and alcohol dependence seems to play a substantial role in explaining the link with peptic ulcer disease.

Lloyd A et., al., (2010),. concluded that type O was significantly greater among those who reacted with an increase of free

hydrochloric acid than other blood group those in whom no increase of acid occurred.

Akira Uehara et., al., (2010),. Concluded that our case reports suggest that psychological stress is still an important clinical factor for peptic ulceration. In the management of patients with peptic ulcer, physicians should pay attention to the possible presence of psychological stress as well as physical causes.

Denis McCarthy et., al., (2010),.States that which involves the impairment of mucosal resistance to injury in an acid-peptic environment, is multi-actorial and controversial. Ulcers caused by NSAIDs can occur either in mucosa inflamed because of infection with *Helicobacter pylori* or in histological normal mucosa. The use of these drugs has been linked to an unexpectedly high incidence of ulcer complications, and a history of peptic ulcer disease is common in such cases. Nonsteroidal anti-inflammatory drugs thus appear both to exacerbate an underlying peptic diathesis and to cause de novo ulcers.

Loes E Visser,**et., al., (2010),.** Concluded that NSAIDs were prescribed to elderly patients after admission to hospital for serious gastrointestinal complications and to study which factors are determinants of the prescription of these contraindicated drugs.

Pedersen NL et., al., (2010),. States that Bisphosphonate increases risk of gastroduodenal ulcer in rheumatoid arthritis patients on long-term nonsteroidalanti inflammatory drug therapy.

Malaty HM et., al., (2010),. concluded that Genetic influences are of moderate importance for liability to peptic ulcer disease. Genetic influences for peptic ulcer are independent of genetic influences important for acquiring H. pylori infection.

PART:III STUDIES RELATED TO PREVENTION OF PEPTIC ULCER

Caroline McCloskey et., al., (2011), concluded that Famotidine is effective in the prevention of gastric and duodenal ulcers, and erosive oesophagitis in patients taking low-dose aspirin. These findings widen the therapeutic options for the prevention of gastrointestinal damage in patients needing vascular protection.

James M et., al., (2011), concluded that Scheiman Acid-suppressive treatment with once-daily esomeprazole 40 mg or 20 mg reduces the occurrence of peptic ulcers in patients at risk for ulcer development who are taking low-dose acetylsalicylic acid(ASA).

Joseph J.Y. Sung, et., al., (2011), states that High-dose intravenous esomeprazole given after successful endoscopic therapy to

patients with high-risk peptic ulcer bleeding reduced recurrent bleeding at 72 hours and had sustained clinical benefits for up to 30 days.

Walid H. Aldoori et., al., (2011), suggest that vitamin A from all sources, as well as diets high in fruits and vegetables, may reduce the development of duodenal ulcer, possibly due to their fiber content.

R.C. Elliott et., al., (2010), concluded that Gastric ulcers were produced in mice by intra peritoneal injections of histamine. The mice were protected from the lethal effects of the histamine by previous administration of mepyramine. When the normal diet of the mice was supplemented with sliced banana for one week prior to the histamine injections there was a significant reduction in the incidence of gastric ulcers

Milly Ryan-Harshman et., al., (2010), suggest that the role of diet in reducing or aggravating risk of duodenal ulcer. A high-fibre diet, particularly if the fibre comes from fruit and vegetables, could reduce risk of DU; vitamin A might also be beneficial.

Grigoris I et., al., (2010), concluded that in ulcer bleeding, proton pump inhibitors reduce rebleeding and the need for surgery and

repeated endoscopic treatment. They improve mortality among patients at highest risk.

GhulamNabiYattoo et., al., (2010), concluded that In patients with bleeding peptic ulcers and signs of recent bleeding, treatment with omeprazole decreases the rate of further bleeding and the need for surgery.

Sugano et. al., (2010) concluded that Lansoprazole was superior to gefarnate in reducing the risk of gastric or duodenal ulcer recurrence in patients with a definite history of gastric or duodenal ulcers who required long-term therapy.

RostomA et. al., (**2010),** demonstrate that misoprostol, proton pump inhibitors, and double doses of H2-receptor antagonists are effective at reducing the risk of both gastric and duodenal non steroidal anti-inflammatory medications induced ulcers. The most effective strategy in high risk GI patients appears to be the combination of a COX-2 inhibitor.

R Jorde et. al., (**2010)** concluded that ranitidine 150 mg at night significantly reduces the gastric ulcer recurrence rate, and that relapsing ulcers are similar to the initial ones in healing response.

Rees et. al., (2010) concluded that Sucralfate has a complex effect on the luminal and mucosal environment of the stomach and duodenum. Some of the actions are important in ulcer healing whilst others are important in preventing subsequent ulcer relapse. Although sucralfate has little direct effect on acid secretion, there is evidence that after ulcer healing with this drug, parietal cell responsiveness is reduced.

KiyonoriKuriki et. al., (2010) concluded that the erythrocyte composition of DHA was found to be negatively linked to risk of gastric cancer, especially of well-differentiated adenocarcinoma.

Amartya Mishra et. al., (2009), concluded that dual action of doxycycline, that is, regulation of MMP matrix metalloproteinase's activity and reduction of oxidative stress in arresting gastric injury

Ogawa Nobuya et. al., (2009), states that cimetidine alone group through 12 weeks observation period. As for the safety, only one patient who received cimetidine alone showed the elevation of .GAMMA.-GTP and LDH which were not serious. Results indicated that combination therapy with egualen sodium and cimetidine would be effective and safe for the prevention of gastric ulcer relapse

CHAPTER – III

METHODOLOGY

CHAPTER-III

METHODOLOGY

Research Methodology is a way to systematically solve the research problems. According to Sharma, the research methodology involves the systematic Procedure by which the Researcher starts from initial identification of the problem to its final conclusion.

The study was aimed at evaluating the knowledge of risk factors and prevention of peptic ulcer.

RESEARCH DESIGN

Quasi experimental in one group pretest and post test design was adopted to evaluate the effectiveness of risk factors and prevention of peptic ulcer.

SETTING OF THE STUDY

The study conducted in co operative sugar mill at Cheyyar taluk.

POPULATION

The population of the study comprised of all the workers who are working in co operative sugar mill at Cheyyar taluk.

SAMPLE SIZE

Total number of sample was 100 who fulfilled the inclusion criteria.

SAMPLE TECHINIQUE

Sampling technique used by the investigator was probability, simple random sampling method. The simple random sampling technique was used to select the samples who were working in co-operative sugar mill at Cheyyar taluk.

SAMPLING CRITERIA

INCLUSION CRITERIA

- Clients who are willing to participate in the study.
- Those who can communicate in English or Tamil.
- The study included both Men and Women.

EXCLUSION CRITERIA

- Clients who are unable to co-operate and respond.
- The clients below 30 years and above 45 years are not taken in to this study.

INSTRUMENTS FOR DATA COLLECTION

Instrument for data collection is derived under the following headings like

SECTION – A

This section consists of information about demographic

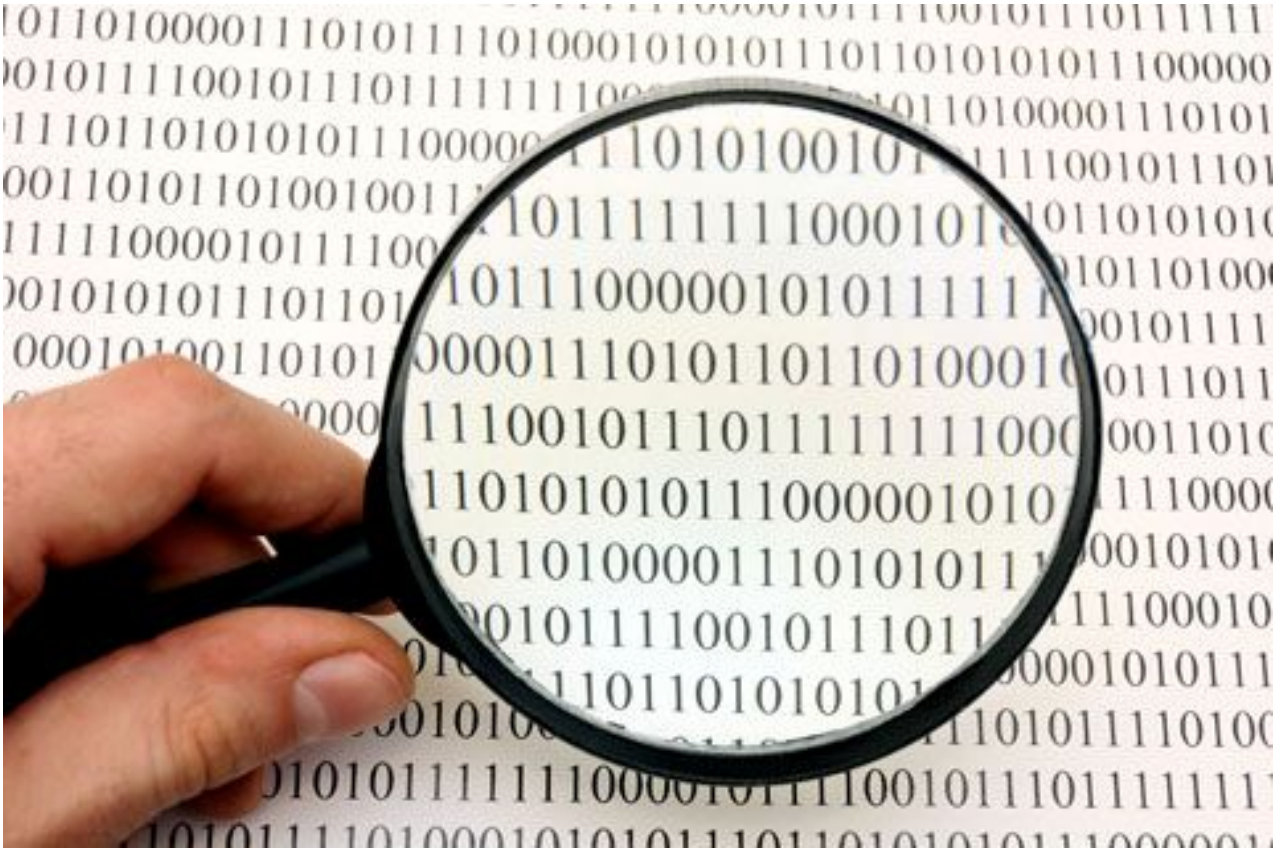
Variables such as age, gender, religion, educational status, occupation, marital status, monthly income, type of family habits, contributory objectives.

SECTION – B

This section consists of 15 questionnaire related to peptic ulcer and 15 questionnaire related to risk factors and prevention of peptic ulcer.

CHAPTER – IV

DATA ANALYSIS AND INTERPRETATION



CHAPTER-IV

DATA ANALYSIS AND INTERPRETATION

This chapter deals with analysis and interpretation of data collected from 100 samples, who were attending co-operative sugar mill workers, effectiveness of structured teaching programme on knowledge regarding risk factors and prevention of peptic ulcer at co-operative sugar factory in Cheyyar taluk.

Data analysis includes both descriptive and inferential statistics. The items had been scored after the pretest and post test and the results had been tabulated. The statistical methods used for analysis were mean, standard deviation, paired‘t’ test and “chi”- square test.

DESCRIPTION OF THE TOOLS

The instrument used for data collection was questionnaire. This was developed based on the objectives of the study and through review of literature.

The instrument consists of two parts.

SECTION – A

This section consists of information about demographic Variables such as age, gender, religion, educational status, occupation, marital status, monthly income, type of family habits, contributory objectives.

SECTION – B

This section consists of 15 questionnaire related to peptic ulcer and 15 questionnaire related to risk factors and prevention of peptic ulcer.

REPORT OF THE PILOT STUDY

The pilot study was conducted to test the reliability, content validity and practicability of the tool. Pilot study was conducted for 10 days.The study was conducted in co-operative sugar mill at cheyyar taluk. Ten workers who met the inclusion criteria had been selected by using simple random sampling technique. Assess the knowledge regarding risk factors and prevention of peptic ulcer among middle age population had been assessed with the questionnaire. The structured teaching programme was given to enhance the knowledge of the clients with the help of education, model, charts, posters and hand out.

VALIDITY

The tool was utilized by the investigator under the guidance of experts and on the basis of objective. The tools had been assessed and evaluated by the experts of research committee and content validity of this instrument was obtained.

RELIABILITY

The reliability was checked by an interater method. The reliability was (0.72) 72% reliability and practicability of tool was tested through the pilot study.

INFORMED CONSENT

The dissertation committee prior to the pilot study approved the research proposal. Permission was obtained from the administrator of co-operative sugar mill in Cheyyar taluk.

DATA COLLECTION PROCEDURE

The data collection procedure was done for six weeks by using questionnaire and observation method. The investigator introduced her to the study participants and developed a good rapport with them.

The investigator explained the purpose of the study and gains the confidence and then introduced the instrument to the clients

All workers participated in the teaching programme with great interest that the same procedure was adopted for six weeks. They were co-operative and attentive. Each week nearly 17 clients had been selected. After seven days, post test with the same questionnaire for the same group of clients was conducted.

SCORE INTERPRETATION

The instrument of part II Consists of 30 multiple choice question regarding peptic ulcer. In each question the maximum score was “1” for correct answer and “0” for wrong answer based on the scoring the percentage of knowledge was calculated using following formula.

$$\frac{\text{Obtained score}}{\text{Total score}} \times 100$$

The score were

LEVEL OF KNOWLEDGE	**SCORE**
Inadequate	≤ 50
Moderately adequate	51-75
Adequate	≥76

SCORE DESCRIPTION

DESCRIPTION	**PERCENTAGE**
Mild	1-50%
Moderate	51-75%
severe	76-100%

METHOD OF DATA ANALYSIS PLAN

S.NO	DATA ANALYSIS	METHOD	REMARKS
1.	Descriptive statistics	Number percentage, mean and standard deviation.	Describes demographic variables and assess the knowledge of pre test and post test.
2.	Inferential statistics	Paired “t” test	Analyzing the effectiveness between pre test and post test.
		Chi-square	To know the association between post test and demographic characteristics of knowledge regarding risk factors and prevention of peptic ulcer among middle age population in industrial workers.

Data analysis was done by using descriptive and inferential according to the need. The items were scored after assessment and evaluation and the results were tabulated. The statistical method used for analysis were mean, standard deviation, paired “t” test and chi-square

STATISTICAL METHOD

TABLE: 4.1 Data analysis and interpretation were done under following headings.

SECTION- A

Distribution of selected demographic variables of co-operative sugar mill workers.

SECTION – B

Percentage of different aspect of knowledge regarding risk factors and prevention of peptic ulcer among middle age population

SECTION- C

Comparison between pre and post test score on knowledge regarding risk factors and prevention of peptic ulcer.

SECTION- D

Association between demographic variables and knowledge regarding risk factors and prevention of peptic ulcer.

SECTION- A

DISTRIBUTION OF SELECTED DEMOGRAPHIC VARIABLES OF CO-OPERATIVE SUGAR MILL WORKERS.

Table: 4.1 Frequency and percentage distribution of demographic variables of industrial workers about peptic ulcer n= 100

S. No	Demographic variables	Number	Percentage (%)
.	**Age in years**		
1.	a.30-35	19	19
	B.36-40.	59	59
	c.41-45	22	22
2.	**Gender**		
	a. Male	90	90
	b. Female	10	10
3.	**Religion**		
	a. Hindu	85	85
	b. Muslim	5	5
	c. Christian	10	10
	d. others	-	-
4.	**Educational Status**		

	a. Illiterate	-	-
	b. Primary school	-	-
	c. High school	5	5
	d. Graduate	50	50
	e.others	45	45
5.	**Marital Status**		
	a. Married	93	93
	b. Unmarried	7	7
	c. widow	-	-
	d. others	-	-
6.	**Monthly Income**		
	a. UptoRs. 3000/-	-	-
	b. Rs.3001/- to Rs.5000/-	-	-
	c. Rs.5001/- to Rs.8000	5	5
	d. Above	95	95
7.	**Type of family**		
	a. Nuclear family	90	90
	b. Joint family	10	10
	c.others	-	-

8.	**occupation**		
	a. Permanent	95	95
	b. Temporary	5	5
9.	**Habit**		
	a. Tobacco	5	5
	b.smoking	25	25
	c.alcohol	15	15
	d. all above	20	20
	e. none	35	35
10.	**contributory objectives**		
	a.hypertension	25	25
	b.diabetes	30	30
	c.both	10	10
	d.none	35	35

Table (4.2) shows the distribution of demographic variables of The workers age of 19% belongs to the age group of 30-35 years. 59% belong to the age group of 36-40 years. 22% belong to the age group of 41-45 years.

With regard to gender 90% male and only 10% female.

In relation to the education status, 5% had high school education. 50% graduates, 45% others.

With regard to occupation, 95 (95%) permanent, five (5%) were temporary.

Regarding marital status, 93% married and 7% unmarried.

In religion, 85% Hindu, 5% Muslim, and 10% Christian.

In relation to the type of family, 90% belong to the Nuclear family and 5% belong to joint family.

Regarding family's monthly income, 5% had income up to Rs.5000-8000. 95% had income above Rs.8000.

In the habits of 5% had tobacco chewing, 25% had the habits of smoking,15% alcohol,20% all the habits,33% clients did not have any bad habits.

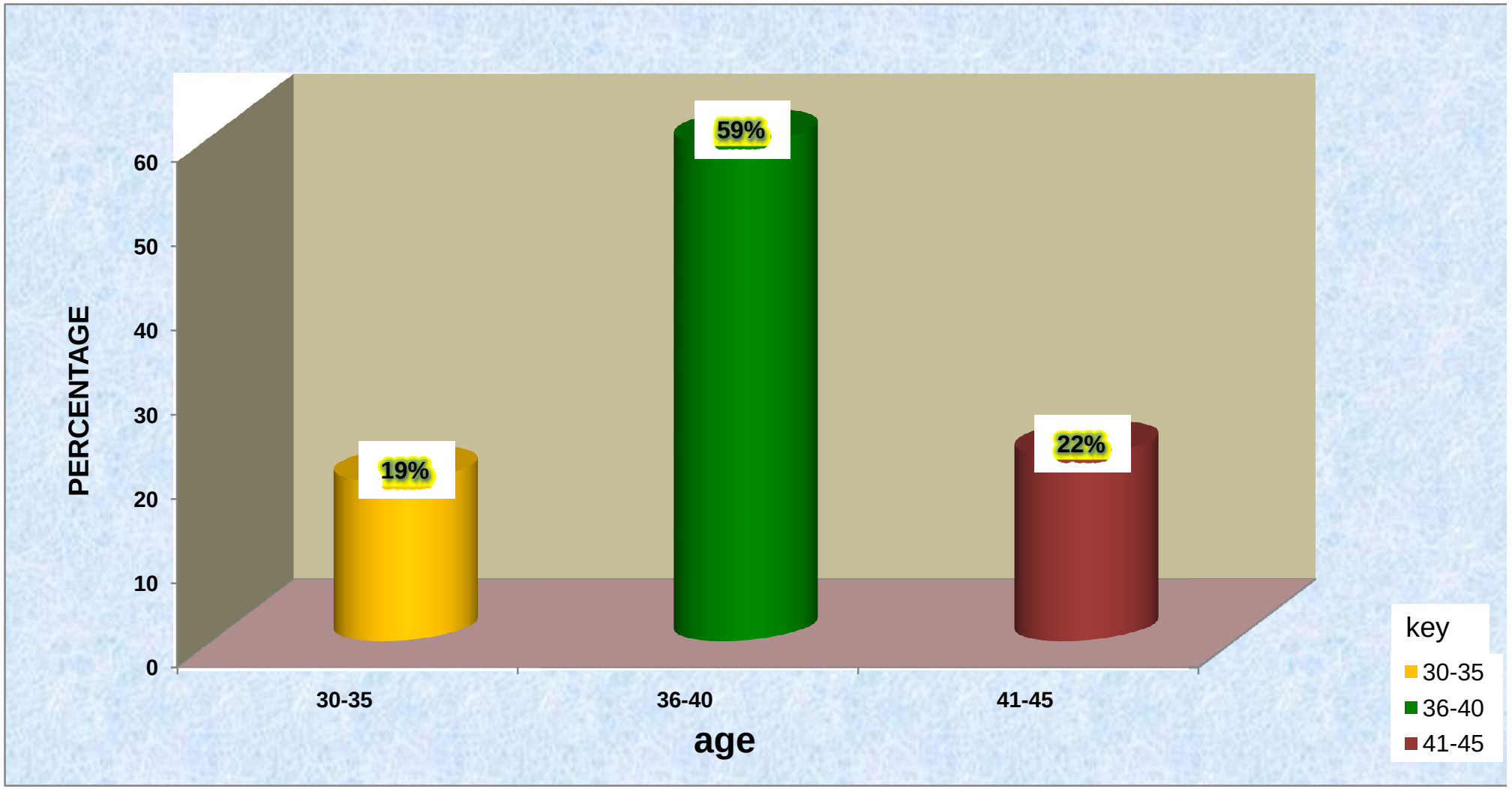


FIG 4.1a percentage distribution of industrial workers based on age (In years)

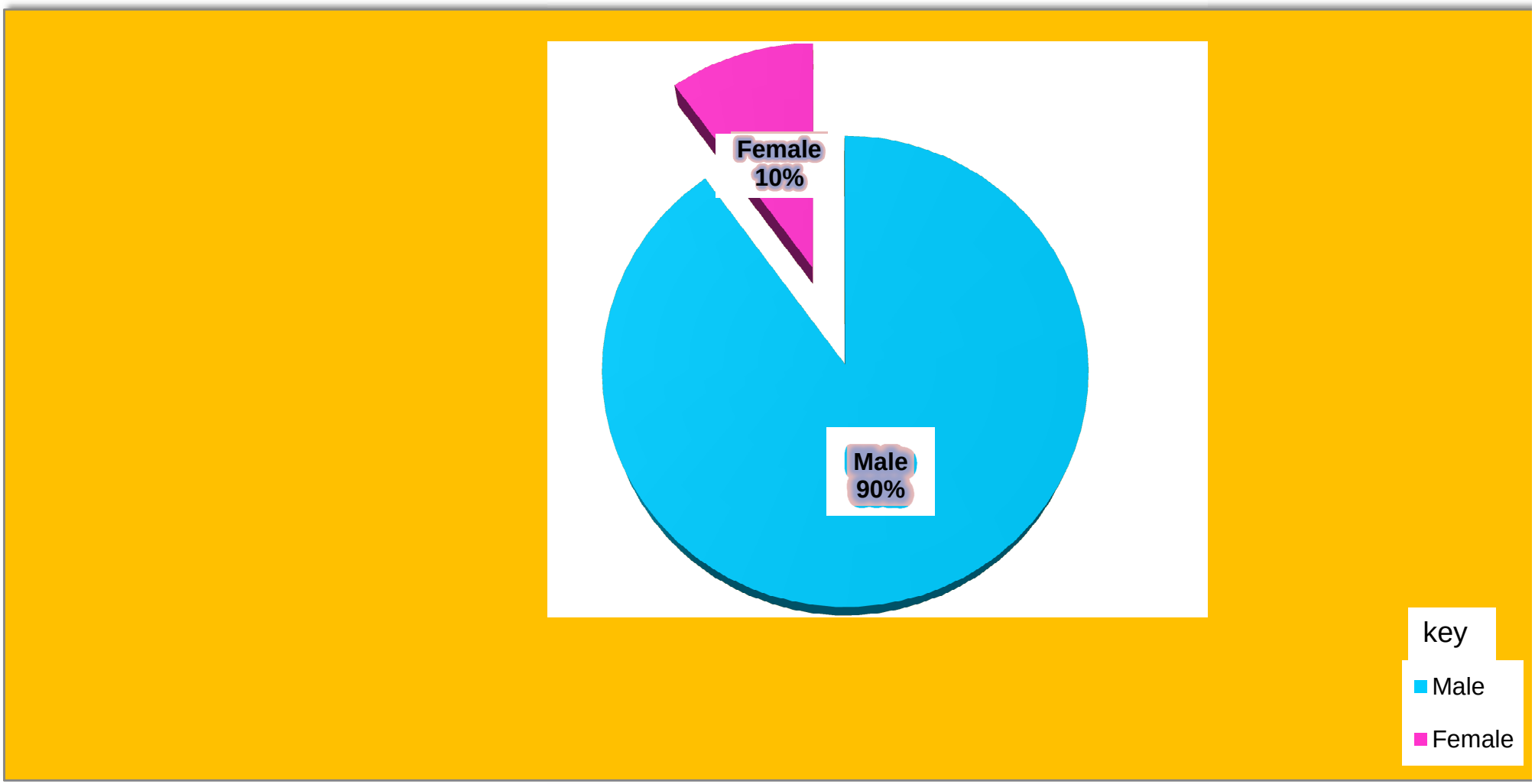


FIG 4.1b PERCENTAGE DISTRIBUTION OF INDUSTRIAL WORKERS BASED ON GENDER

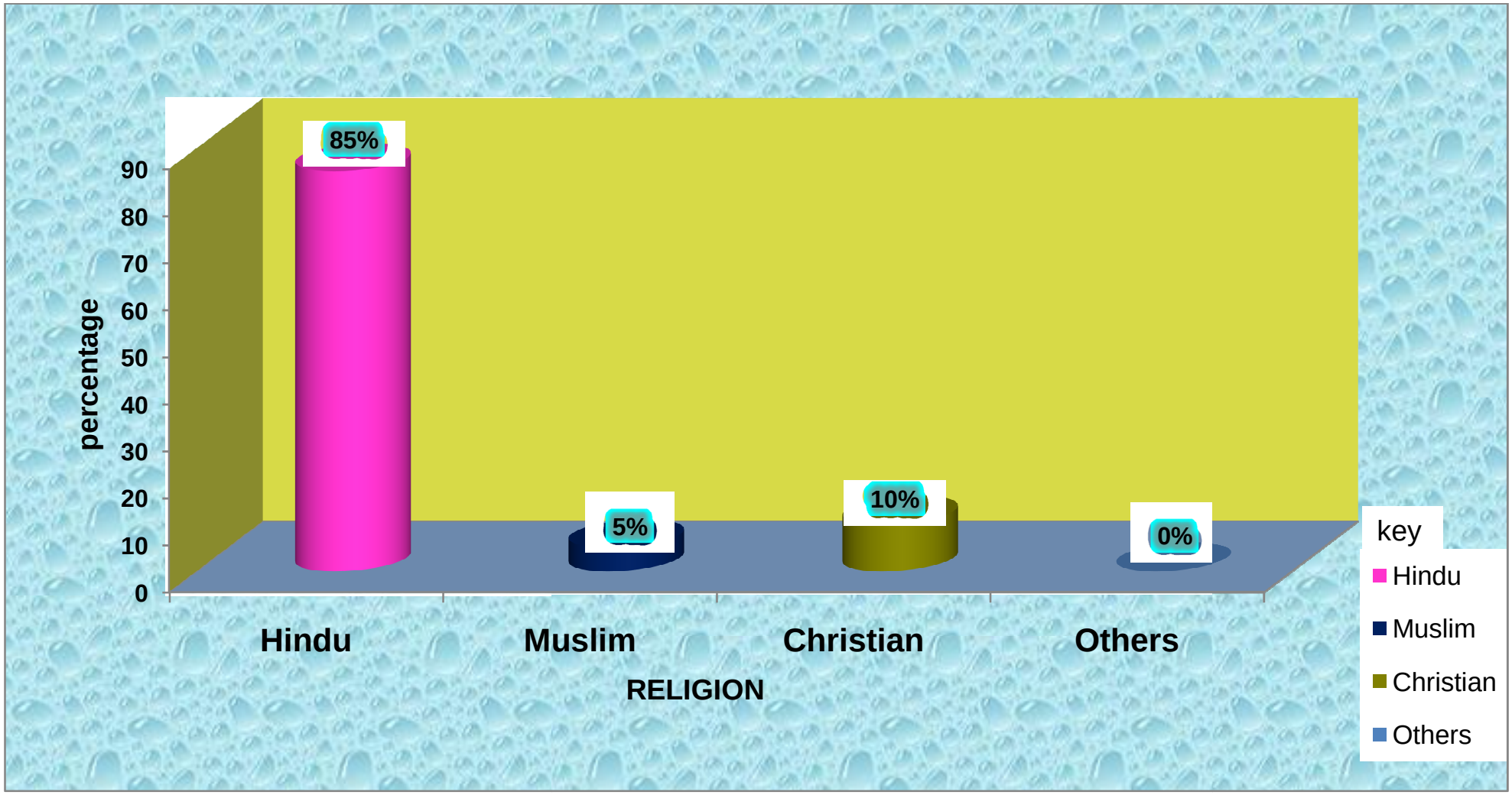


FIG 4.1 C: PERCENTAGE DISTRIBUTION OF INDUSTRIAL WORKERS BASED ON RELIGION

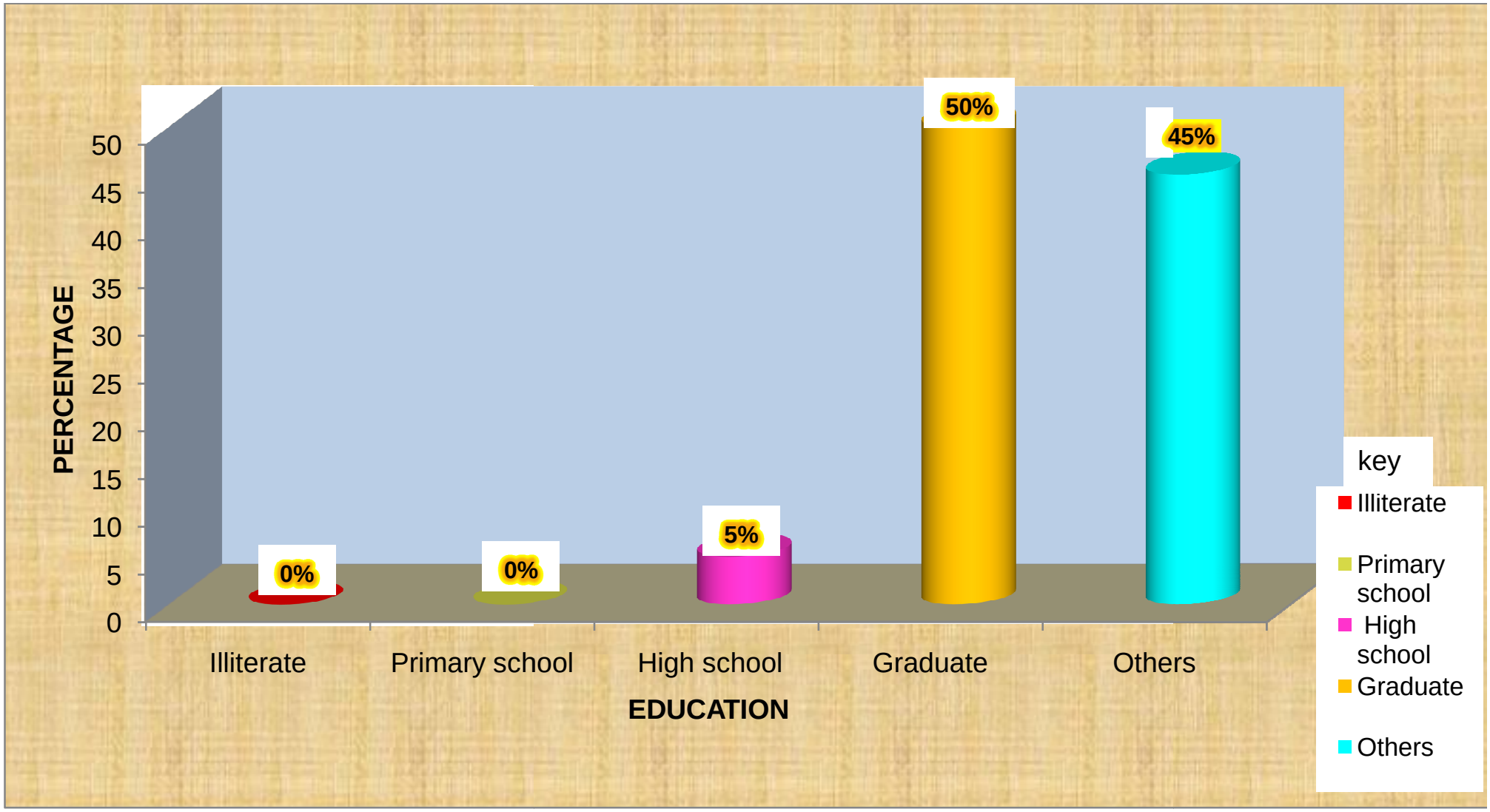


FIG 4.1d: percentage distribution of industrial workers based on education

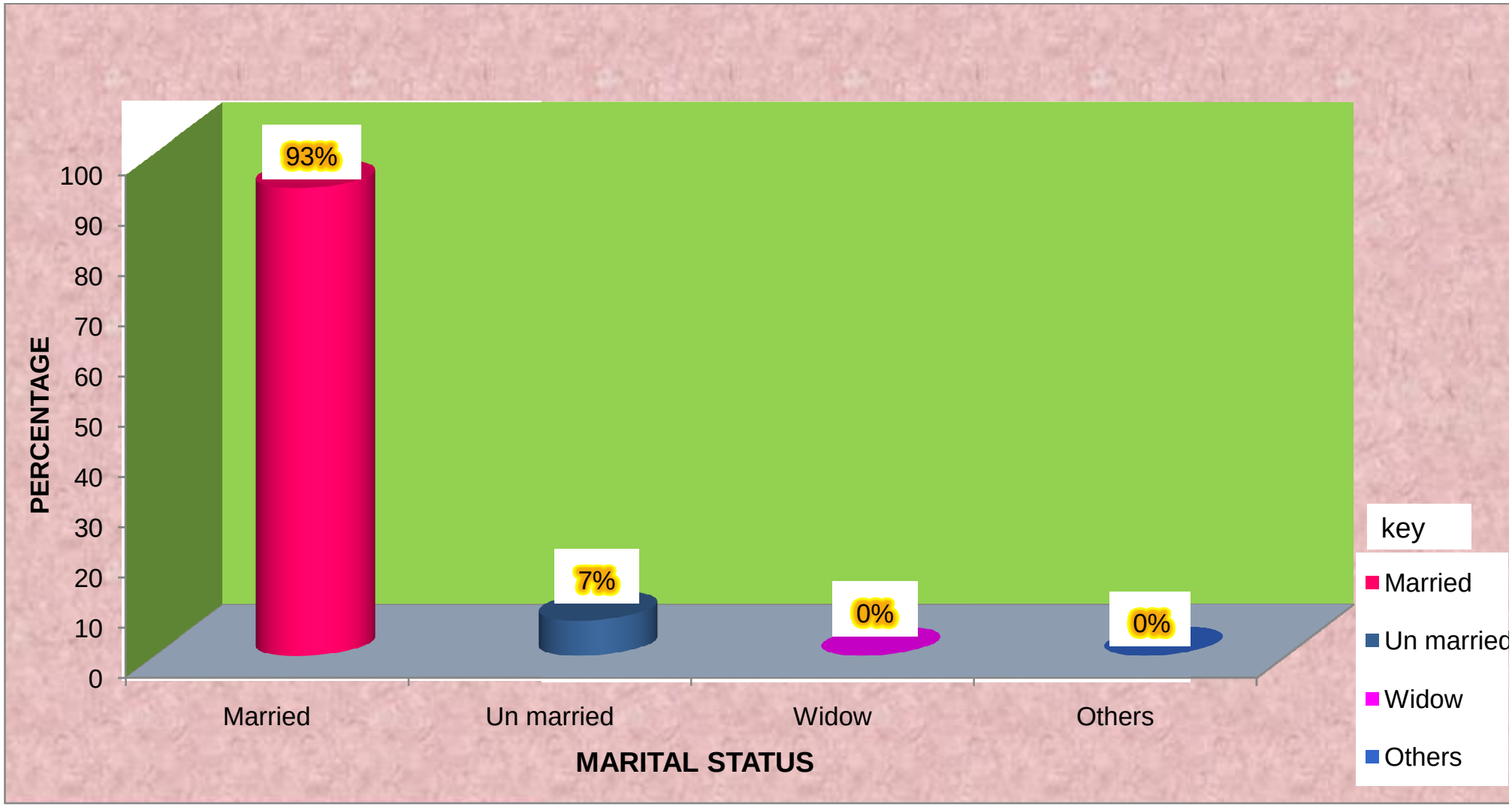


Fig 4.1 d percentage distribution of industrial workers based on marital status

SECTION- B

PERCENTAGE OF DIFFERENT ASPECTS OF KNOWLEDGE REGARDING RISK FACTORS AND PREVENTION OF PEPTIC ULCER AMONG MIDDLE AGE POPULATION.

Table: 4.2 Level of knowledge regarding risk factors and prevention of peptic ulcer among middle age population in industrial workers

LEVEL OF KNOWLEDGE	ADEQUATE KNOWLEDGE		MODERATE KNOWLEDGE		INADEQUATE KNOWLEDGE		TOTAL	
	No	%	No	%	No	%	No	%
Pre test	0	0	34	34	66	66	100	100
Post test	89	89	11	11	0	0	100	100

Table 4.2 shows that the knowledge regarding peptic ulcer through the pre tests and post test based on questionnaire method. On the pre test among middle age population in 100 industrial workers 34 (34%) moderately adequate knowledge, 66 (66%) industrial workers had inadequate knowledge. In the post test 89 (89%) had adequate knowledge, 11 (11%) industrial workers had moderately adequate knowledge and none of them was in inadequate knowledge.

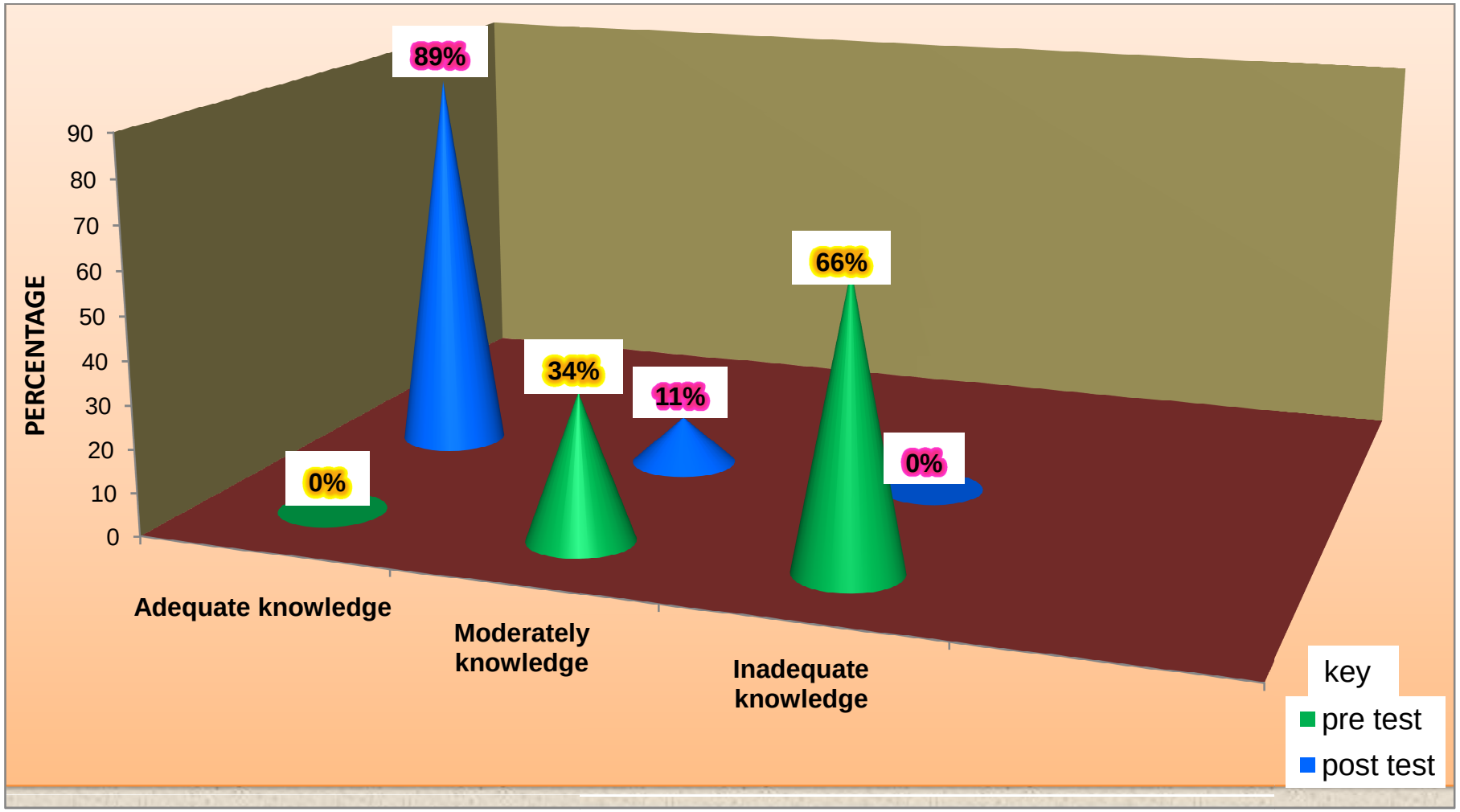


Fig 4.2a Percentage distribution of level of knowledge regarding risk factors and prevention of peptic ulcer

SECTION-C

COMPARISON BETWEEN PRETEST AND POST TEST SCORES ON KNOWLEDGE REGARDING RISK FACTORS AND PREVENTION OF PEPTIC ULCER

Table: 4.3 comparisons of mean scores between pretest and posttest on knowledge regarding risk factors and prevention of peptic ulcer among middle age population in industrial workers

n=100

S.NO	LEVEL OF KNOWLEDGE	MEAN	STANDARD DEVIATION	CONFIDENCE INTERVAL
1	PRE TEST	13.75	4.02	14.53-12.96
2.	POST TEST	26.20	2.42	26.67-25.72

Table 4.3 Shows that the over all mean of knowledge regarding risk factors and prevention of peptic ulcer among middle age population was 13.75 with the confidence interval of 11.69 and standard deviation of 4.02 in pre test and the overall mean of knowledge regarding peptic ulcer in post test was 26.20 with the confidence interval of 13.20 and standard deviation of 2.42.

Table: 4.4

Improvement of mean and standard deviation of pre and post test scores for knowledge regarding risk factors and prevention of peptic ulcer

n=100

S. NO	LEVEL OF KNOWLEDGE	MEAN	STANDARD DEVIATION	't' VALUE	CONFIDENCE INTERVAL
1.	Improvement score	12.45	3.80	32.70	13.1948-11.7052

Table 4.4 reveals that the mean and standard deviation of improvement score for effectiveness of structured teaching programme on peptic ulcer it measures among middle age population in selected 100 industrial workers. The improvement score of mean value was 12.45 with the standard deviation of 3.80 and the't' test value was 32.70 which were statistically significant. It implies that the structured teaching programme was effective and showed improvement in knowledge level of middle age population about peptic ulcer at $P<0.05$

SECTION- D

ASSOCIATION BETWEEN DEMOGRAPHIC VARIABLES AND KNOWLEDGE REGARDING RISK FACTORS AND PREVENTION OF PEPTIC ULCER

Table :4.5 Association between knowledge and demographic variables of risk factors and prevention of peptic ulcer among middle age population in industrial worker n =100

DEMOGRATPHIC VARIYABLES		POST TEST SCORE						χ^2
		INADEQUATE		MODERATLY ADEQUATE		ADEQUATE		
		NO	%	NO	%	NO	%	
AGE	a.30-35 YEARS	0	0%	2	2%	18	18%	0.202
	b.36-40 YEARS	0	0%	6	6%	52	52%	
	c.41-45 YEARS	0	0%	3	3%	19	19%	
SEX	a.MALE	0	0%	9	9%	81	81%	0.919
	b.FEMALE	0	0%	2	2%	8	8%	

RELIGION	**a.HINDU** **b.MUSLIM** **c.CHRISTIAN** **d.OTHERS**	0 0 0 0	0% 0% 0% 0%	10 0 1 0	10% 0% 1% 0%	75 5 9 0	75% 5% 9% 0%	0.679
EDUCATION	**a.ILLITRATE** **b.PRIMARY SCHOOL** **c.HIGH SCHOOL** **d.GRADUATE** **e.OTHERS**	0 0 0 0 0	0% 0% 0% 0% 0%	0 0 3 1 7	0% 0% 3% 1% 7%	0 0 2 49 38	0% 0% 2% 49% 38%	17.35 *
MARITAL STATUS	**a.MARRIED** **b.UNMARRIED** **c.WIDOW** **d.OTHERS**	0 0 0 0	0% 0% 0% 0%	10 1 0 0	10% 1% 0% 0%	83 6 0 0	83% 6% 0% 0%	0.83
FAMILY INCOME	**a.UPTO Rs 3000** **b.Rs3001-5000** **c.Rs5001-8000** **d.ABOVERs8000**	0 0 0 0	0% 0% 0% 0%	0 0 3 8	0% 0% 3% 8%	0 0 2 87	0% 0% 2% 87%	12.90 *

TYPES OF FAMILY	**a.NUCLEAR** **b.JOINT** **c.OTHERS**	0 0 0	0% 0% 0%	10 1 0	10% 1% 0%	80 9 0	80% 9% 0%	0.011
OCCUPATION	**a.PERMANENT** **b.TEMPORARY**	0 0	0% 0%	10 1	10% 1%	85 4	85% 4%	0.435
HABITS	**a.TOBACCO CHEWING** **b.SMOKING** **c.ALCOHOLISM** **d.SMOKING & ALCOHOLISM** **e.NONE**	0 0 0 0 0	0% 0% 0% 0% 0%	1 3 1 1 5	1% 3% 3% 1% 5%	4 22 14 19 30	4% 22% 14% 19% 30%	1.848
CONTRIBUTORY OBJECTIVES	**a.HYPERTENSION** **b. DIABETES** **c.BOTH** **d.NONE**	0 0 0 0	0% 0% 0% 0%	3 4 0 4	3% 4% 0% 4%	22 26 10 31	22% 26% 10% 31%	1.435

****p<0.05 level of significance**

Table (4.5) reveals that the association between demographic variables and knowledge regarding risk factors and prevention of peptic ulcer among middle age population in industrial workers. Statistically there was a significant association between the demographic variables such as family income and education. But statistically there was no significant association between the demographic variables such as age, sex, religion, marital status, and occupation, type of family, habit and contributory objectives.

CHAPTER – V

RESULTS AND DISCUSSION

CHAPTER-V

RESULTS AND DISCUSSION

The aim of the present study was to evaluate the effectiveness of structured teaching programme of clients with peptic ulcer in middle age population.

A total number of 100 samples had been selected for the study. Pre test was conducted by using questionnaires. After 7 days post test was conducted by using the same questionnaire.

The first objective was to assess the existing knowledge of the client with peptic ulcer.

In pretest the data analysis showed that 66% possessed inadequate knowledge, 34% possessed moderately adequate knowledge, 0% possessed adequate knowledge.

It revealed that there was a lack of knowledge on risk factors and prevention of peptic ulcer in over all, the pre test knowledge means score was 13.75 with the standard deviation of 4.02. The post test knowledge mean score was 26.20 with standard deviation of 2.42.

The second objective was to find out the effectiveness of structured teaching programme of clients with peptic ulcer.

Table 4.3 revealed that most of clients with peptic ulcer had inadequate knowledge with the mean of 13.75. During the post test it was found that the clients with peptic ulcer gained knowledge with the mean value of 26.20. In these results showed the lack of knowledge of clients with peptic ulcer. The total knowledge mean score in post test was high that of 12.45. This showed that the knowledge has increased markedly after structured teaching programme.

The third objective was to find out the association between post test knowledge levels with their selected demographic variables.

There was a significant association between the demographic variables such as family income and education. But statistically there was no significant association between the demographic variables such as age, sex, religion, marital status, and occupation, type of family, habit and contributory objectives.

The overall finding of the study showed that the structured teaching programme is very effective in improving the knowledge of clients with peptic ulcer.

CHAPTER – VI

SUMMARY AND CONCLUSION

CHAPTER- VI

SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

The present study was conducted to assess the knowledge of clients with peptic ulcer.

The study was quasi experimental study with 100 industrial workers, who met the inclusion criteria had been selected from the industrial workers by using the simple random sampling technique. The investigator first introduced her to the clients and developed a rapport with them. After the selection of sample the interview was conducted with the instrument.

SUMMARY OF THE STUDY

The purpose of the study was to assess the effectiveness of structure teaching programme on knowledge regarding risk factors and prevention of peptic ulcer among middle age population in co-operative sugar mill in Cheyyar taluk.

Quasi experimental, one group pre test – post test design was used in the study.

The conceptual frame work of this study was based on **ALBWIGN VON BETTANLAFFY**

The instrument used for data collection was knowledge questionnaire regarding risk factors and prevention of peptic ulcer. Simple random sampling technique was used for this study to select the samples. Descriptive statistics (frequency, percentage, mean and standard deviation) and inferential statistics (chi – square, paired “t” test) were used to analyze the data and to test hypothesis.

The major study findings were as follows:

The maximum numbers of industrial workers 59% were in the age group of 36-40 years.

The maximum numbers of industrial workers of 90.0% were male.

The proportion of 100 industrial workers 50.0% were graduates.

The proportion of 100 industrial workers 95% had been earning above Rs.8000 per month

The proportion of 100 industrial workers 93% got married.

The proportion of 100 industrial workers 95% was permanent.

The proportion of 100 industrial workers 25.0% had the habit of smoking. The level of knowledge was inadequate among 66%, and moderately adequate among 34.0% before structure teaching programme.

The level of knowledge was adequate among 89% and it was moderately adequate in 11% after the structure teaching programme.

The mean knowledge regarding risk factors and prevention of peptic ulcer in the pre test was 13.75 and in the post test was 26.20 respectively.

The revealed structure teaching programme was found effective in improving the knowledge regarding risk factors and prevention of peptic ulcer.

There was a significant difference in the mean scores between pre test and posttest in relation to knowledge risk factors and prevention of peptic ulcer.

There is a significant association between the knowledge and demographic variable education, family income of industrial workers at $P<0.05$ level.

CONCLUSION

The following conclusions had been derived based on the study findings:

Structure teaching programme was effective to increase the knowledge regarding risk factors and prevention of peptic ulcer among middle age population Co-Operative Sugar Mill at Cheyyar Taluk.

As per the study findings, the level of knowledge was adequate only 0% in the pre test, where as during post test; the level of knowledge of study subjects was adequate among 89% and none of them was inadequate level of knowledge.

There was a significant difference in the mean scores between pretest and posttest in relation to knowledge risk factors and prevention of peptic ulcer among middle age population.

There is significant association between the knowledge and demographic variable education and family income of the peptic ulcer at $p<0.05$ level.

IMPLICATIONS

Implication for Nursing Practice

The planned health teaching programme are to be scheduled in the co-operative sugar mill at Cheyyar. The fixed date and time for clients as well as to family members.

The study also implying the need for integral services, feedback, follow up and collaborative services of all industrial workers.

Peptic ulcer can be prevented by public awareness which implies the need for change that has to be introduced by the industrial workers.

Implication for nursing education

The present study trends in health care delivery system emphasis more on prevention than curative aspects.

The study also implies that health personnel have to be properly trained as how to teach the public regarding peptic ulcer, nursing students to assess the lifestyle practices to identify the warning signs of clients with peptic ulcer and to provide supportive educative care of the self care in preventing complications.

Nursing educators, when the plan to instruct the students, should provide adequate opportunity for them to develop themselves for handling the clients with peptic ulcer and provide health education both community and clinical settings.

The study findings suggest that the content of subject should include the new vies of clients with peptic ulcer and in risk factors and prevention of peptic ulcer.

Implication of nursing administration

The leaders in nursing are confronted to undertake the health needs of the most vulnerable by effective organization and management.

The nursing administration should take active part in health policy making development protocol, procedures and standing orders related to client's education.

The nurse administration should give attention the proper selection, placement and effective utilization of the nurses in all areas with in the available recourses giving importance for their creativity, interest, ability in education of the clients.

The education programme on educative role of the nurses along with the adequate supervision of nursing services could motivate nurses to carry out educative roles.

Implication of nursing research

The finding of the study to help the professional nurses and sudden to develop the inquiry by providing a baseline. The general aspects of the study results can be made by further replication of the study. This study help the nurse researchers to develop in depth in to the development of teaching module and set information of clients with peptic ulcer towards the promotion of healthy life and prevent of complication.

RECOMMENDATION

Based on the findings of present study the following recommendation was made:

- Experimental study can be done to assess the knowledge of people regarding peptic ulcer disease.
- A similar study can be conducted on people residing in community area.
- The study will help to conduct health educationprogramme regarding peptic ulcer.
- A comparative study can also be done between rural and urban in peptic ulcer.

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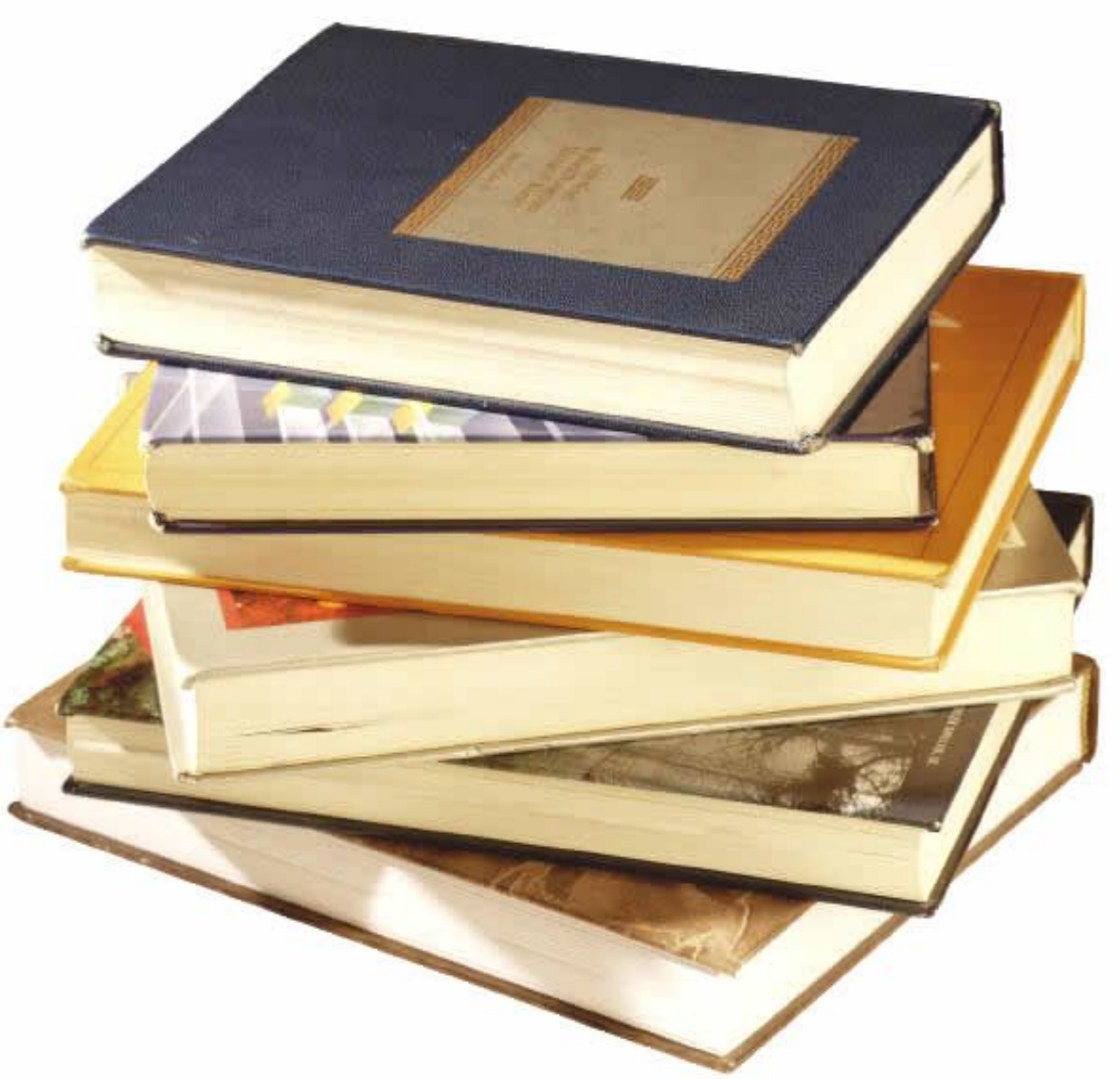

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APPENDICES

SECTION – A

Demographic variables

1.Age group in years

a) 30 - 35 [ ]

b) 36 - 40 [ ]

c) 41 - 45 [ ]

2. Sex

a) Male [ ]

b) Female [ ]

3. Religion

a) Hindu [ ]

b) Muslim [ ]

c) Christian [ ]

d)others [ ]

4. Educational Status

a) Illiterate [ ]

b) Primary level [ ]

c) High school level [ ]

d) Graduate and Post graduate [ ]

e)others

5. Marital status

a.Unmarried [ ]

b.Married [ ]

c.Widow [ ]

d.others

6. Family income

a) upto Rs.3000 [ ]

b) Rs.3001 – 4000 [ ]

c) Rs.4001 – 5000 [ ]

d) Above Rs.5000 [ ]

7. Types of family

a) Nuclear family [ ]

b) Joint family [ ]

c) Extended family [ ]

d) Separated

8. Occupation

a) Permanent [ ]

b) Temporary [ ]

c) Technical [ ]

d) Nontechnical [ ]

9. Habits

a) Tobacco chewing [ ]

b) Smoking [ ]

c) Alcoholism [ ]

d) Smoking and alcoholism [ ]

e) None [ ]

10. Contributory objective

a) Hypertension [ ]

b) Diabetes [ ]

c) Hypertension and diabetes [ ]

d) None [ ]

INTRODUCTION:

The following questions are based on knowledge regarding PEPTIC ULCER.

Note: Please select only one option given below.

Score:

Correct Answer: 1

Wrong Answer: 0

KNOWLEDGE REGARDING PEPTIC ULCER

1) The term peptic ulcer is known as

a) Decreased acid secretion [ ]

b) Increased acid secretion [ ]

c) Decreased salivary secretion [ ]

d) Increased salivary secretion [ ]

2) Most affected area in peptic ulcer

a) Small and large intestine [ ]

b) Stomach and duodenum [ ]

c) Liver and gallbladder [ ]

d) Esophagus and trachea [ ]

3) The condition which ulceration to be produced

a) Increased blood supply and alkaline pH [ ]

b) Decreased blood supplies and alkaline p [ ]

c) Increased blood supply and acidic pH [ ]

d) Increased blood supply and salivary secretion [ ]

4) The effect of ingestion of food in gastric ulcer patient

a) Increase pain [ ]

b) Decrease pain [ ]

c) Increase fever [ ]

d) Decrease fever [ ]

5) Most common symptoms of duodenal ulcer

a) Cold [ ]

b) Pain before meals [ ]

c) Fever [ ]

d) Bleeding [ ]

6) Heart burn is seen in

a) Myocardial infraction [ ]

b) Peptic ulcer [ ]

c) Ulcerative colitis [ ]

d) Intestinal obstruction [ ]

7) A peptic ulcer the pain mostly occurs

a) In early morning [ ]

b) Before taking food [ ]

c) After taking food [ ]

d) During night [ ]

8) Tenderness occurs in peptic ulcer during gentle pressure over the area of

a) Neck region [ ]

b) Back [ ]

c) Epigastria region [ ]

d) Chest [ ]

9) Blood vomiting is commonly occurs

a) Ulcerative colitis [ ]

b) Intestinal obstruction [ ]

c) Gastric ulcer [ ]

d) Duodenal ulcer [ ]

10) The weight gain occurs in which ulcer

a) Gastric ulcer [ ]

b) Oral ulcer [ ]

c) Duodenal ulcer [ ]

d) Corneal ulcer [ ]

11) Most common complication of peptic ulcer is

a) Dysentery [ ]

b) Fever and vomiting [ ]

c) Radiculitis [ ]

d) Legs syndrome [ ]

12) A person can reduce gastric ulcer pain

a) Taking food [ ]

b) Induced vomiting [ ]

c) Smoking [ ]

d) Alcohol [ ]

13) The drug for peptic ulcer

a) Antihypertensive [ ]

b) Antacid [ ]

c) Non-steroid [ ]

d) Antipyretic [ ]

14) The general management for peptic ulcer

a) Proper immunization and hygiene [ ]

b) Stress relief and rest [ ]

c) Continuous smoking and alcohol [ ]

d) Taking solid and semisolid foods [ ]

15) Suitable pattern of taking diet in peptic ulcer patient

a) Small meals more frequently [ ]

b) Small meals less frequently [ ]

c) Irregular [ ]

d) Regular meals [ ]

KNOWLEDGE REGARDING RISK FACTORS AND PREVENTION OF PEPTIC ULCER

16) Peptic ulcer disease commonly occurs in human beings at the age group in human beings at the age group of

a) Below 20 years [ ]

b) 21-40 years [ ]

c) 41-60 years [ ]

d) Above 60 years [ ]

17) The important factors which predispose human being peptic ulcer

a) Improper hygiene and improper sanitation [ ]

b) Drug, smoke and stress [ ]

c) Over eating and non spicy foods [ ]

d) Diabetes mellitus and congestive cardiac failure [ ]

18) Hereditary disease of

a) Peptic ulcer [ ]

b) Osteoarthritis [ ]

c) Congestive heart failure [ ]

d) Cerebral palsy [ ]

19) There are certain drugs that stimulate the peptic ulcer

a) NSAID [ ]

b) Antispasmodic [ ]

c) Antiepileptic [ ]

d) Antiemetic [ ]

20) Untimely consuming food leads to

a) Corneal ulcer [ ]

b) Peptic ulcer [ ]

c) Oral ulcer [ ]

d) Skin ulcer [ ]

21) Burning sensation of stomach due to

a) HCL [ ]

b) H_2NO_3 [ ]

c) NH_3 [ ]

d) KNO_3 [ ]

22) Peptic ulcer affected from

a) Bacteria [ ]

b) Virus [ ]

c) Fungi [ ]

d) None [ ]

23) Bacteria pass from

a) Person to person [ ]

b) Person to animal [ ]

c) Animal [ ]

d) Flies [ ]

24) Increased acid secretion due to

a) Smoking and alcohol [ ]

b) Workload [ ]

c) Walking [ ]

d) Standing [ ]

25) Risk factors for peptic ulcer is

a) H.Pylori [ ]

b) Streptococcus [ ]

c) Staphylococcus [ ]

d) None [ ]

26) The blood group affected more in peptic ulcer is

a) Blood group A [ ]

b) Blood group B [ ]

c) Blood group O [ ]

d) Blood group AB [ ]

27) Important method used to prevent the peptic ulcer

a) Lifestyles changes and medication [ ]

b) Continuous smoking and alcohol [ ]

c) Ingestion of spicy foods and stimulating food [ ]

d) Continuous taking of NSAIDS [ ]

28) A peptic ulcer patient has to avoid the intake of

a) Bland diet [ ]

b) Milk and cream [ ]

c) Antacid [ ]

d) Spicy foods [ ]

29) Stress reduction is due to

a) Reduced production of secretion in the stomach [ ]

b) Increased production of secretion in the stomach [ ]

c) Fever [ ]

d) Stomatitis [ ]

30) The drink mostly prefer in early morning

a) Water [ ]

b) Tea [ ]

c) Milk [ ]

d) Rice flakes and porridge [ ]

HEALTH EDUCATION

ON

PEPTIC ULCER

SUMITTED TO

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CENTRAL OBJECTIVE

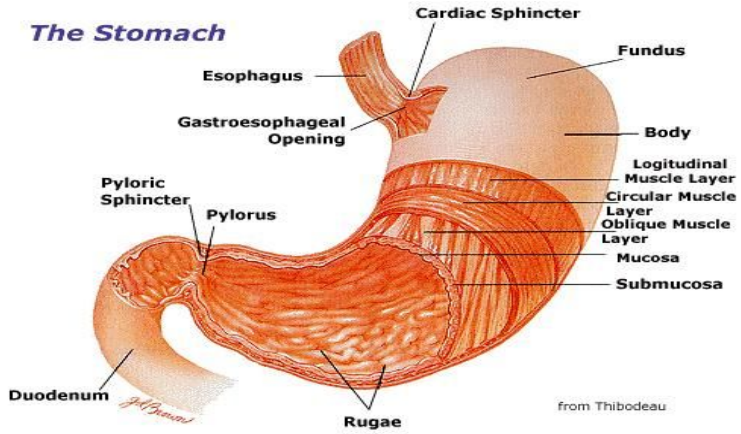
At the end of the session the individuals can able to understand the risk factors and prevention of peptic ulcer and desire attitude and gain the knowledge about the peptic ulcer

CONTRIBUTORY OBJECTIVE

The clients will be able to

- Explain the review of anatomy and physiology of stomach
- Define peptic ulcer
- Describe the causes and incidence of peptic ulcer
- Explain the risk factors of peptic ulcer
- Describe the pathophysiology of peptic ulcer
- Enumerate the clinical manifestation and diagnosis of peptic ulcer
- List out the complication and differential diagnosis of peptic ulcer
- Explain the management and prevention of peptic ulcer

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
1.	5min	**explain the review of anatomy and physiology of stomach**	**REVIEW OF ANATOMY AND PHYSIOLOGY OF STOMACH** The stomach is a pyriform sac the longitudinal diameter of which is as a rule oblique in position. The larger part of the organ is situated higher up and more to the left than the smaller, which is directed to the right somewhat upward and sometimes backward. This smaller extremity terminates in the small intestine. The point at which the stomach communicates with the small intestine is called pylorus (P) and is recognizable on its outer surface by a furrow and on its inner surface by a protruding fold (valvula pylori). The communication between the esophagus and the stomach is called the cardiac (C) and is situated at the upper part. A straight line (AB) drawn in the direction of the esophagus and prolonged through the stomach would cut off one-fourth or one-fifth of this organ to the left. This portion to the left is called the greater cul-de-sac (saccus caecus) (F) or fundus. The volume of the stomach varies according to the condition of its	Explaining	listening

S. NO	Time	Contributory objective	content	Teacher ‘s activity	Learner’s activity
			contents. When tilled its long diameter measures 26 to 31 cm. the transverse diameter being 8 to 10 cm. at the fundus and much less at the pylorus. Here it measures about 2.6 cm. When the stomach is filled the anterior wall turns somewhat upward and the posterior downward (a rotation of the organ takes place).  		

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			The stomach lies on the left side of the body, and only one-sixth of it is situated on the right side. This includes the pylorus and the adjacent parts which lie behind the liver (lobus Spigelii). The cardia is situated in the left parasternal line, somewhat above the ensiform process; the lesser curvature lies on the left side, close to the vertebral column and runs downward and parallel with it. The greater curvature extends from the base of the gall bladder and the liver into the left hypochondriac region in which the whole of the fundus is found. Blood-Vessels The blood-vessels enter the stomach at its upper and lower borders and thus divide the surface of the stomach into two equal parts. These lines mark the superior and inferior margins of the stomach, the upper and lower curvature, or the lesser and greater curvature. **The Relations of the Stomach to Neighboring Organs** The left segment of the stomach is in contact with the diaphragm above, and to the left with the spleen and the left kidney. The lesser curvature and	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			the adjacent part of the organ are in relation with the pancreas, and the splenic artery and vein. The greater curvature and a portion of the front wall as well as the pylorus touch the liver and also the transverse colon. **Structure of the Stomach** The stomach has four coats, the serous, muscular, areola or sub mucous, and mucous. The serous coat is derived from the peritoneum and forms a thin, contain parietal or oxyntic cells, which are closely arranged in the neck of the glands. They are recognizable by being of a more or less cuboids shape and having a dark granular appearance. They are stained quite deeply with the aniline dyes. The other cells of the glands are called the principal cells, and are somewhat smaller in shape and not so dark as the parietal cells.	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			PEPTIC ULCER		
			Definition of Peptic ulcer:		
2.	3 min	**define the peptic ulcer**	A peptic ulcer is erosion in the lining of the stomach or the first part of the small intestine, an area called the duodenum. If the peptic ulcer is located in the stomach, it is called a gastric ulcer.	Explaining	Listening
			INCIDENCE		
3.	3 min	**describe the incidence and causes of peptic ulcer**	Prevalence of H. pylori infection correlates with socio-economic status rather than race, with a prevalence of 80% in developing countries compared to prevalence of 20-50% in developed countries. In the United States the probability of being infected is greater for older persons, with prevalence rates greater than 50% in individuals older than 50 years and older. Minorities of varying age groups have a higher prevalence 40 to 50%, and immigrants from developing countries such as Latinos have prevalence rates greater than 60%. The infection is less common in more affluent Caucasians at 20% for individuals less than 40 years of age.[i]		

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			Although most gastric ulcers are usually caused by H. pylori, reports from the US show that 30% of gastric ulcers can be related to aspirin and other non-steroidal anti-inflammatory drugs (NSAIDs). Most gastric adenocarcinomas and lymphomas occur in persons with current or past infection with H. pylori. In developing countries, the ulcer groups are smaller and the gastric cancer group may be larger. For example, in northern Brazil, gastric cancer is the most common malignancy in men. **Western countries** In general, the following statements can be made to summarize prevalence of H Pylori in Western countries: ▪ H Pylori affects about 20% of persons below the age of 40 years, and 50% of those above the age of 60 years. ▪ H Pylori is uncommon in young children. ▪ Low socio-economic status predicts H Pylori infection. ▪ Immigration is responsible for isolated areas of high prevalence in some Western countries.	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			Developing Countries In developing countries, most adults are infected. H Pylori infection which occurs in about 10% of children annually between the ages of 2 and 8 years so that most are infected by their teens. It is evident from careful surveys that the majority of persons in the world are infected with H Pylori. H pylori can be cultured from the stools in most infected persons This is evidence that spread by fecal oral contact with infected persons is likely. In addition, polymerase chain reaction (PCR) can detect H Pylori in dental plaque from 30% of persons with the gastric infection. However, this may be a less common source of transmission. **CAUSES** "*Helicobacter pyloricus*" (H. pylori). H. pylori bacteria are very common, infecting more than a billion people worldwide. It is estimated that half of the United States population older	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			than age 60 has been infected with *H. pylori*. Infection usually persists for many years, leading to ulcer disease in 10 % to 15% of those infected. *H. pylori* are found in more than 80% of patients with gastric and duodenal ulcers. While the mechanism of how *H. pylori* cause ulcers is not well understood, elimination of these bacteria by antibiotics has clearly been shown to heal ulcers and prevent ulcer recurrence. Anti-inflammatory medications, commonly referred to as NSAIDs (nonsteroidal anti-inflammatory drugs), including aspirin. NSAIDs are medications for arthritis and other painful inflammatory conditions in the body. Aspirin, ibuprofen (Motrin), naproxen (Naprosyn), and etodolac (Lodine) are a few of the examples of this class of medications. Prostaglandins are substances which are important in helping the gut linings resist corrosive acid damage. NSAIDs cause ulcers by interfering with prostaglandins in the stomach. Cigarette smoking Cigarette smoking not only causes ulcer formation, but also increases the risk of ulcer complications such as ulcer	Explaining	listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			bleeding, stomach obstruction and perforation. Cigarette smoking is also a leading cause of ulcer medication treatment failure. Contrary to popular belief, alcohol, coffee, colas, spicy foods, and caffeine have no proven role in ulcer formation. Similarly, there is no conclusive evidence to suggest that life stresses or personality types contribute to ulcer disease.		
4	10 min	**explain the risk factors of peptic ulcer**	**RISK FACTORS** A risk factor is something that increases your likelihood of getting a disease or condition. It is possible to develop peptic ulcer disease with or without the risk factors listed below. However, the more risk factors you have, the greater your likelihood of developing peptic ulcer disease. If you have a number of risk factors, ask your doctor what you can do to reduce your risk. Risk factors for peptic ulcers fall into two categories: • Factors that actually cause peptic ulcers	Explaining	listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			• Factors that irritate your stomach or increase acid production, making you more susceptible to *H. pylori* infection Lifestyle Factors • Some studies suggest that cigarette smoking can increase the risk of *H. pylori* and can slow the healing of peptic ulcers. • Drinking acidic beverages such as fruit juices and consuming caffeine-containing foods and beverages can cause stomach irritation and increase production of stomach acid. This can make you more susceptible to *H. pylori* infection. • Alcohol in large quantities can irritate your stomach, leading to an increased susceptibility to *H. pylori* . • Alcohol taken while you are using nonsteroidal anti-inflammatory agents can further irritate your stomach, increasing your chance of developing a peptic ulcer. • Even in the absence of alcohol misuse, certain anti-inflammatory medications (including aspirin and most other drugs commonly	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			available over-the-counter or by prescription as "nonsteroidals") can increase the risk of peptic ulcer. These drugs are responsible for at least half of all peptic ulcers in elderly persons. Helicobacter Pylori Infection Infection with *Helicobacter pylori* is the most well-defined risk factor for the development of peptic ulcers. You have an increased risk of being infected with *H. pylori* if you: • Live in crowded conditions • Live in unsanitary conditions • Use certain medications, including: o Nonsteroidal anti-inflammatory medications o COX-2 inhibitors o Corticosteroid drugs (although this connection is less clear than the others) • Had prior peptic ulcer disease • Have Zollinger-Ellison syndrome	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			• Recently had major surgery • Recently suffered severe injury or burns • Had head trauma • Had :radiation therapy • Have congenital malformations of the stomach and/or duodenum • Have specific malignant diseases such as mastocytosis and basophilic leukemia Age • Duodenal ulcers: More common between ages 30-50 years old • Gastric ulcer: More common in people over age 60 years old Gender • Duodenal ulcers: Twice as likely in men • Gastric ulcers: More common in women Genetic Factors You're more likely to develop a peptic ulcer if you have other family	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
5.	3min	**describe the patho physiology of peptic ulcer**	members who have had ulcers. Other Risk Factors • Stress is no longer believed to actually cause ulcers. However, many researchers still believe that stress can play a role in exacerbating symptoms and slow healing of pre-existing peptic ulcers. • You may have an increased risk of peptic ulcers if you have type O blood **PATHOPHYSIOLOGY** Due to any cause ↓ Too much of acid and pepsin secretion ↓ Break the lining of the stomach and duodenum ↓ Peptic ulcer	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
6.	5 min	**Enlist the signs and symptoms of peptic ulcer**	**SIGNS & SYMPTOMS** The most common symptom of a peptic ulcer is a gnawing or burning pain in the abdomen between the breastbone and navel. Duodenal ulcers typically cause symptoms 2 to 5 hours after meals, when the stomach is empty, and can be relieved by eating. Gastric ulcers, on the other hand, are classically made worse by eating. You may experience pain soon after meals, and food won't improve symptoms. For each, the duration of pain can be from a few minutes to a few hours. o Vomiting blood o Vomiting food eaten hours or days before • Difficulty swallowing • Nausea • Black or tar-like stool (indication that there is blood in T the stool)	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher ‘s activity	Learner’s activity
7.	10 min	**Explain the diagnosis and of peptic ulcer**	• Sudden, severe pain in the abdominal area • Pain that radiates to the back • Pain that doesn't go away when you take medication • Unintended weight loss • Unusual weakness, usually because of anemia **DIAGNOSIS** Testing for Bacterial Infection Most peptic ulcers are caused by a bacteria known as H. Pylori. Confirming the presence of H. pylori is important because elimination of the bacteria is likely to cure the ulcer. Any number of blood, breath, and stomach tissue tests may be performed to detect the presence of H. pylori. None of the tests are foolproof -- blood tests on occasion give false positive results, and the other tests may give false negative results in people who have recently taken antibiotics, omeprazole (Prilosec), or bismuth (Pepto-Bismol).	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			Blood Tests Blood tests such as the enzyme-linked immunosorbent assay (ELISA) and quick office-based tests identify and measure H. pylori antibodies. The body produces antibodies against H. pylori in an attempt to fight the bacteria. Blood tests are inexpensive and easy to use for doctors. However, the disadvantage is that there is an increased risk of getting a false-positive test, especially in people who have had an H. pylori infection in the past. Breath Tests Breath tests measure the amount of carbon dioxide in exhaled breath. Patients are given a substance called urea with carbon to drink. Bacteria break down this urea and the carbon is absorbed into the blood stream and lungs, and exhaled in the breath. By collecting the breath, doctors can measure this carbon and determine whether H. pylori is present or absent. Urea breath tests are at least 90 percent accurate for diagnosing the	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			bacteria and are particularly suitable to follow-up treatment to see if bacteria have been eradicated. Tissue Tests If the doctor performs an endoscopy to diagnose an ulcer, tissue samples of the stomach can be obtained. The doctor may then perform one of several tests on the tissue. First, a rapid urease test detects the presence of bacterial enzymes. Second, the bacteria can be examined under a microscope, and growing the organisms in a laboratory (bacterial culture) can allow a doctor to more definitively find out if the bacteria is H. pylori. Barium X-rays Barium x-rays (also referred to as a Barium Swallow) is an examination of the esophagus and stomach using a solution with barium. The patient drinks the solution, which coat the walls of the upper digestive tract so that they may be examined under x- ray. Barium swallows are used to identify ulcers, and any abnormalities of the upper gastrointestinal tract such as tumors, hernias, pouches, strictures, and swallowing difficulties. However,	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			the presence of H. Pylori cannot be detected from the barium x-ray alone. If ulcers aren't treated or treatment isn't effective, serious complications may occur. The most common complications include bleeding, perforation of the stomach or duodenal walls, and obstruction of the digestive tract. **DIFFERENTIAL DIAGNOSIS**		
8.	5 min	**Listout the differential diagnosis and complications of peptic ulcer**	• Peptic ulcer • Gastritis • Stomach cancer • Gastroesophageal reflux disease • Pancreatitis • Hepatic congestion • Cholecystitis • Biliary colic • Inferior myocardial infarction • Referred pain (pleurisy, pericarditis)	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			Superior mesenteric artery syndrome **Complication** Bleeding As an ulcer erodes the muscles of the stomach or duodenal wall, blood vessels may also be damaged, which causes the bleeding. If the affected blood vessels are small, the blood may slowly seep into the digestive tract. Over a long period of time, a person may become anemic. If a damaged blood vessel is large, bleeding is dangerous and requires prompt medical attention. The symptoms of bleeding include feeling weak and dizzy when standing, vomiting blood, or fainting. The stool may become a tarry, black color from the blood. Most bleeding ulcers can be treated endoscopically by locating the ulcer and cauterizing the blood vessel with a heating device or injecting it with material to stop bleeding. If endoscopic treatment is unsuccessful, surgery may be required. Perforation Sometimes an ulcer eats a hole in the wall of the stomach or duodenum.	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			Bacteria and partially digested food can spill through the opening into the sterile abdominal cavity (peritoneum). A perforated ulcer can cause peritonitis, an inflammation of the abdominal cavity and wall. The symptoms of a perforated ulcer include sudden, sharp, severe pain. Immediate hospitalization and surgery is usually required. Narrowing and obstruction Ulcers located at the end of the stomach where the duodenum is attached may cause swelling and scarring. These ulcers can narrow or close the intestinal opening, and can prevent food from leaving the stomach and entering the small intestine. As a result, a person may vomit the contents of the stomach. Endoscopic balloon dilation may be performed. The endoscopic balloon procedure uses a balloon to force open a narrowed passage. If the dilation does not relieve the problem, then surgery may be necessary.	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
9	5min	**explain the treatment of peptic ulcer**	**TREATMENT** Younger patients with ulcer-like symptoms are often treated with antacids or H2 antagonists before EGD is undertaken. Bismuth compounds may actually reduce or even clear organisms though the warning labels of some bismuth subsalicylate products indicate that the product should not be used by someone with an ulcer.[20] Patients who are taking nonsteroidal anti-inflammatories (NSAIDs) may also be prescribed a prostaglandin analogue (Misoprostol) in order to help prevent peptic ulcers, which may be a side-effect of the NSAIDs. When *H. pylori* infection is present, the most effective treatments are combinations of 2 antibiotics (e.g. Clarithromycin, Amoxicillin, Tetracycline, Metronidazole) and 1 proton pump inhibitor (PPI), sometimes together with a bismuth compound. In complicated, treatment-resistant cases, 3 antibiotics (e.g. amoxicillin + clarithromycin + metronidazole) may be used together with a PPI and sometimes with bismuth compound. An effective first-line therapy for uncomplicated cases would be Amoxicillin +	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			Metronidazole + Pantoprazole (a PPI). In the absence of *H. pylori*, long-term higher dose PPIs are often used. Treatment of *H. pylori* usually leads to clearing of infection, relief of symptoms and eventual healing of ulcers. Recurrence of infection can occur and retreatment may be required, if necessary with other antibiotics. Since the widespread use of PPI's in the 1990s, surgical procedures (like "highly selective vagotomy") for uncomplicated peptic ulcers became obsolete. Perforated peptic ulcer is a surgical emergency and requires surgical repair of the perforation. Most bleeding ulcers require endoscopy urgently to stop bleeding with cautery, injection, or clipping. Ranitidine provides relief of peptic ulcers, heartburn, indigestion and excess stomach acid and prevention of these symptoms associated with excessive consumption of food and drink. Ranitidine is available over the counter from a pharmacy and works by decreasing the amount of acid the stomach produces allowing healing of ulcers. Zantac tablets contain	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			Ranitidine 150 mg as the active ingredient which can also be bought generically.[21] Sucralfate, (Carafate) has also been a successful treatment of peptic ulcers.[22] **DIET** Eat 5 to 6 small meals a day instead of 3 larger meals. It is important that you avoid overeating. Frequent, smaller meals will be more comfortable and easier on the stomach than two or three large meals a day. ▪ Eat a diet rich in fiber, especially from fruits and vegetables ▪ Rest and relax a few minutes before and after each meal, as well as remaining relaxed during meals. ▪ Eat slowly and chew you food well ▪ Avoid eating within 3 hours before bedtime ▪ Eat foods that are low fat	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			▪ Avoid foods that are fried ▪ Avoid foods that are spicy ▪ Cut down on the following foods: ▪ Coffee ▪ Decaffeinated coffee ▪ Tea ▪ Cola drinks ▪ Carbonated beverages ▪ Citrus fruits ▪ Tomato-based products	Explaining	Listening
10.	5min	**Explain the prevention of peptic ulcer**	**PREVENTION** There is no proven way to prevent peptic ulcer disease. But several lifestyle changes may reduce the risk of ulcers. **Curb NSAID use**: NSAIDs (nonsteroidal anti-inflammatory drugs) appear to cause ulcers by inhibiting the body's production of prostaglandins,		

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			hormones that protect the stomach lining. If possible, avoid these drugs—or use the lowest possible dose for the shortest possible time. Package labeling on most NSAIDs recommends using the drugs for no longer than 10 days in a row. If you feel you need to control pain longer, discuss the treatment with your doctor. **Get tested for** *H. pylori:* If you're over 60 years old, have previously had an ulcer, or have a family history of ulcers, you should ask your doctor about being tested for infection with the bacterium, a major cause of ulcers. It is estimated that half of the United States population older than 60 has been infected. There are several tests for *H. pylori,* and you and your doctor can decide which is best for you. **Stop smoking**: Smokers are about two times as likely to develop ulcers as nonsmokers. Cigarette smoking may increase susceptibility to *H. pylori,* provide a more favorable milieu for the bacteria to thrive, or diminish gastric mucosal defenses. **Reduce stress**: There's conflicting evidence about the role of	Explaining	Listening

S. NO	Time	Contributory objective	content	Teacher 's activity	Learner's activity
			psychological stress in peptic ulcer disease; it may exacerbate ulcers rather than cause them. Acute stress increases pulse rate, blood pressure, and anxiety, yet only in patients with duodenal ulcers has stress been shown to increase acid secretion. Relaxation exercises, meditation, and other stress-reducing strategies have been shown to reduce blood pressure and slow heart rate. While they may not prevent ulcer formation, they remain sound wellness practices. **Watch alcohol intake:** Contrary to popular belief, alcohol, coffee, colas, spicy foods, and caffeine have no proven role in ulcer formation. But alcohol, like smoking, is known to worsen ulcers and aggravate pain.	Explaining	Listening

நேர்காணல் அட்டவணை

பகுதி I

1. வயது (வருடங்கள்)
   - (அ) 30-35 வரை [ ]
   - (ஆ) 36-40 வரை [ ]
   - (இ) 41-45 வரை [ ]

2. பாலினம்
   - (அ) ஆண் [ ]
   - (ஆ) பெண் [ ]

3. மதம்
   - (அ) இந்து [ ]
   - (ஆ) கிறிஸ்துவர் [ ]
   - (இ) முஸ்லீம் [ ]
   - (ஈ) மற்றவை [ ]

4. கல்வி தகுதி
   - (அ) படிக்காதவர் [ ]
   - (ஆ) ஆரம்பக்கல்வி [ ]
   - (இ) உயர்கல்வி [ ]
   - (ஈ) பட்டபடிப்பு [ ]

5. திருமணத் தகுதி
   - (அ) திருமணம் ஆகாதவர் [ ]
   - (ஆ) திருமணம் ஆனவர் [ ]
   - (இ) விதவை [ ]
   - (ஈ) மற்றவை [ ]

6. மாத வருமானம் (ரூபாயில்)

(அ) 3000-க்கு கீழ் [ ]

(ஆ) 3001-5000 வரை [ ]

(இ) 5001-8000 [ ]

(ஈ) 8001-க்கு மேல் [ ]

7. குடும்ப வகை

(அ) தனிகுடும்பம் [ ]

(ஆ) கூட்டுக்குடும்பம் [ ]

(இ) மற்றவை [ ]

8. தொழில்

(அ) நிரந்தரமான வேலை [ ]

(ஆ) நிரந்தரமில்லாத வேலை [ ]

9. பழக்க வழக்கம்

(அ) புகையிலை [ ]

(ஆ) புகைபிடித்தல் [ ]

(இ) மது அருந்துதல் [ ]

(ஈ) புகைபிடித்தல், மது அருந்துதல், புகையிலை [ ]

(உ) எதுவுமில்லை [ ]

10. காரணிகள்

(அ) இரத்த அழுத்தம் [ ]

(ஆ) நீரிழிவு நோய் [ ]

(இ) இரத்த அழுத்தம் மற்றும் நீரிழிவு நோய் [ ]

(ஈ) எதுவுமில்லை [ ]

வயிற்றுப்புண் சம்பந்தப்பட்ட கேள்விகள்

1. வயிற்றுப்புண் என்பது
   (அ) குறைவாக அமிலம் சுரத்தல் [ ]
   (ஆ) அதிகமாக அமிலம் சுரத்தல் [ ]
   (இ) குறைவாக உமிழ்நீர் சுரத்தல் [ ]
   (ஈ) அதிகமாக உமிழ்நீர் சுரத்தல் [ ]

2. வயிற்றுப்புண்ணால் அதிகளவு பாதிக்கப்படும் உறுப்பு
   (அ) சிறுகுடல் மற்றும் பெருங்குடல் [ ]
   (ஆ) வயிறு மற்றும் டியோடினம் [ ]
   (இ) கல்லீரல் மற்றும் பித்தநீர் பை [ ]
   (ஈ) உணவுக்குழாய் மற்றும் சுவாசக்குழாய் [ ]

3. வயிற்றுப்புண் எதனால் ஏற்படுகிறது?
   (அ) அதிக இரத்த ஓட்டம் மற்றும் காரத்தன்மை [ ]
   (ஆ) குறைந்த இரத்தஓட்டம் மற்றும் காரத்தன்மை [ ]
   (இ) அதிக இரத்தஓட்டம் மற்றும் அமிலத்தன்மை [ ]
   (ஈ) அதிக இரத்தஓட்டம் மற்றும் உமிழ்நீர் சுரப்பி [ ]

4. உணவு உண்டபின் வயிற்றுப்புண்ணின் விளைவு
   (அ) வலி அதிகமாகும் [ ]
   (ஆ) வலி குறையும் [ ]
   (இ) காய்ச்சல் அதிகமாகும் [ ]
   (ஈ) காய்ச்சல் குறையும் [ ]

5. குடல் புண்ணால் ஏற்படும் அறிகுறிகள்
   (அ) சளிப்பிடித்தல் [ ]
   (ஆ) சாப்பிடுவதற்கு முன் வலி ஏற்படுதல் [ ]
   (இ) காய்ச்சல் [ ]
   (ஈ) இரத்தக்கசிவு [ ]

6. நெஞ்செரிச்சல் மனிதனில் எந்த நோய் வந்தால் காணப்படுகிறது
   (அ) இதயநோய் [ ]
   (ஆ) குடல்வால் வீக்கம் [ ]
   (இ) வயிற்றுப்புண் [ ]
   (ஈ) குடல் அடைப்புநோய் [ ]

7. எந்த நேரங்களில் வயிற்றுப்புண் வலி உண்டாகும்

(அ) விடியற்காலையில் [ ]
(ஆ) சாப்பிடுவதற்குமுன் [ ]
(இ) சாப்பிடுவதற்கு பிறகு [ ]
(ஈ) இரவு நேரம் [ ]

8. வயிற்றுப்புண் உள்ளவர்களுக்கு எந்த இடத்தில் தொட்டால் வலி உருவாகும்.

(அ) கழுத்து பகுதி [ ]
(ஆ) முதுகு பகுதி [ ]
(இ) மேல் வயிற்றுபகுதி [ ]
(ஈ) நெஞ்சு பகுதி [ ]

9. இரத்தம் கலந்த வாந்தி காணப்படுவது

(அ) குடல் வால் வீக்கம் [ ]
(ஆ) குடல் அடைப்பு நோய் [ ]
(இ) வயிற்றுபுண் நோய் [ ]
(ஈ) குடல் புண் நோய் [ ]

10. உடல் எடை அதிகரிப்பது எந்த வகையான புண்

(அ) வயிற்றுபுண் [ ]
(ஆ) வாய்புண் [ ]
(இ) குடல் புண் [ ]
(ஈ) கருவிழி புண் [ ]

11. வயிற்றுபுண்ணால் ஏற்படும் முக்கியமான விளைவுகள்

(அ) காய்ச்சல் மற்றும் வாந்தி [ ]
(ஆ) வயிற்றில் துளை மற்றும் இரத்தபோக்கு [ ]
(இ) வாந்தி மற்றும் பேதி [ ]
(ஈ) சீதபேதி மற்றும் காய்ச்சல் [ ]

12. வயிற்றுபுண்ணில் ஏற்படும் வலியை குறைக்க எந்த முறையை மேற்கொள்ள வேண்டும்.

(அ) உணவு உட்கொள்ள வேண்டும் [ ]
(ஆ) வாந்தி எடுக்க வைக்க வேண்டும் [ ]
(இ) ஓய்வு எடுக்க வேண்டும் [ ]
(ஈ) மது அருந்த வேண்டும் [ ]

13. வயிற்று புண்ணிற்கு எடுத்துக்கொள்ள வேண்டிய மருந்துகள்.

(அ) மன அழுத்தத்திற்கான மருந்துகள் [ ]
(ஆ) இரத்த அழுத்தத்திற்கான மருந்துகள [ ]
(இ) சீரான உறுப்புகளின் அமிலத்தன்மை குறைப்பதற்கான மருந்துகள் [ ]
(ஈ) காய்ச்சலை குறைப்பதற்கான மருந்துகள [ ]

14. வயிற்று புண்ணிற்கான பொதுவான சிகிச்சை முறை

(அ) சரியான தடுப்புமுறை மற்றும் சுயசுத்தம [ ]

(ஆ) மன அழுத்தத்திலிருந்து விடுபடுதல் மற்றும் ஓய்வு எடுத்தல் [ ]

(இ) தொடர்ந்து புகைபிடித்தல் மற்றும் மது அருந்துதல [ ]

(ஈ) திடஉணவு மற்றும் திண்ம உணவு வகைகள [ ]

15. வயிற்று புண் உள்ளவர்களின் பொறுத்தமான உணவு உண்ணும் முறை.

(அ) குறைந்த அளவு உணவு போதிய இடைவெளியில் எடுத்துக் கொள்ளுதல் [ ]

(ஆ) குறைந்த அளவு உணவு குறைந்த இடைவெளியில் எடுத்துக் கொள்ளுதல[ ]

(இ) சீரற்ற முறையில் உணவை எடுத்துகொள்ளுதல் [ ]

(ஈ) ஒழுங்கான முறையில் உணவை எடுத்து கொள்ளுதல் [ ]

வயிற்றுபுண்ணின் ஆபத்து காரணிகள் மற்றும் தடுப்பு முறைகள்

16. மனிதர்களில் எந்த வயதினற்கு பொதுவாக வயிற்றுபுண் நோய் காணப்படுகிறது

(அ) 20 வயதிற்கு கீழ் [ ]

(ஆ) 21-40 வயது வரை [ ]

(இ) 41-60 வயது வரை [ ]

(ஈ) 61 வயதிற்கு மேல் [ ]

17. மனிதனில் வயிற்றுப்புண் வருவதற்கான மிக முக்கிய காரணங்களுள் ஒன்று

(அ) சத்தம் மற்றும் சுகாதாரம் அற்றநிலை [ ]

(ஆ) மருந்துப்பொருட்கள், புகைபிடித்தல் மற்றம் மன அழுத்தம் [ ]

(இ) அதிகம் உணவு உட்கொள்ளுதல் மற்றும் கார உணவு வகைகள் [ ]

(ஈ) நீரிழிவு நோய் மற்றும் இதய நோய் [ ]

18. மரபு வழியில் வந்த நோய்

(அ) வயிற்று புண் [ ]

(ஆ) மூட்டு வலி [ ]

(இ) இதய நோய் [ ]

(ஈ) பக்கவாதம் [ ]

19. சிலவகையான மருந்துகள் வயிற்று புண்ணை ஏற்படுத்துகிறது.

(அ) என்.எஸ்.ஏ.ஐ.டி [ ]

(ஆ) ப்ராக்ஸிவான் [ ]

(இ) ப்னைடாயின் [ ]

(ஈ) ஆம்பிசிலின் [ ]

20. உரிய நேரத்தில் தொடர்ந்து உணவை உட்கொள்ளவில்லை என்றால் உடலில் வரும் புண்

(அ) வாய் புண் [ ]
(ஆ) வயிற்று புண் [ ]
(இ) கருவிழிபுண் [ ]
(ஈ) தோல் புண் [ ]

21. வயிற்று எரிச்சல் உண்டாவது

(அ) Hcl [ ]
(ஆ) H_2NO_3 [ ]
(இ) NH_3 [ ]
(ஈ) KNO_3 [ ]

22. வயிற்றுபுண் வருவதற்கான காரணம்

(அ) பாக்டீரியா [ ]
(ஆ) வைரஸ் [ ]
(இ) பூஞ்சை [ ]
(ஈ) எதுவுமில்லை [ ]

23. பாக்டீரியா பரவுவது

(அ) மனிதனிடமிருந்து மனிதனுக்கு [ ]
(ஆ) விலங்குகள் [ ]
(இ) பறவைகள் [ ]
(ஈ) விலங்குகளிடமிருந்து மனிதனுக்கு [ ]

24. அதிகமான சுரப்பிகள் சுரப்பதற்கான காரணிகள்

(அ) புகைபிடித்தல் மற்றும் மது அருந்துதல [ ]
(ஆ) வேலைபளு [ ]
(இ) நடப்பது [ ]
(ஈ) நிற்பது [ ]

25. வயிற்றுப்புண்ணின் ஆபத்துக் காரணிகள்

(அ) எச்.பைலோரி [ ]
(ஆ) ஸ்டெரெப்டோ காக்கஸ் [ ]
(இ) ஸ்டெப்லோ காக்கஸ் [ ]
(ஈ) எதுவுமில்லை [ ]

26. வயிற்றுப்புண்ணால் அதிகமாக பாதிக்கப்படும் இரத்தவகை

(அ) இரத்தவகை ஏ [ ]
(ஆ) இரத்தவகை பி [ ]
(இ) இரத்தவகை ஏபி [ ]
(ஈ) இரத்தவகை ஓ [ ]

27. வயிற்றுப்புண் வராமல் தடுப்பதற்கான வழிமுறைகள்

(அ) வாழ்க்கை முறையை மாற்றியமைத்தல் மற்றும் தியானம் [ ]

(ஆ) தொடர்ந்து புகைபிடித்தல் மற்றும் மது அருந்துதல [ ]

(இ) கார உணவுகள் உண்ணுதல் [ ]

(ஈ) என்.எஸ்.ஐ.டி உட்கொள்ளுதல [ ]

28. வயிற்றுப்புண் உள்ளவர்கள் உட்கொள்ளக் கூடாதவை

(அ) காரவகையற்ற உணவு [ ]

(ஆ) பால் மற்றும் க்ரீம் [ ]

(இ) ஆன்டாஸிட் [ ]

(ஈ) கார வகையான உணவு [ ]

29. மன அழுத்தம் குறைவதால்

(அ) சீரான உறுப்புகளில் அமிலத்தன்மை குறைவது [ ]

(ஆ) சீரான உறுப்புகளின் அமிலத்தன்மை அதிகரிப்பது [ ]

(இ) மன அழுத்தம் அதிகரிப்பது [ ]

(ஈ) குறைவான உடல் அசைவு [ ]

30. விடியற்காலையில் குடிக்கும் பொருள்

(அ) நீர் [ ]

(ஆ) டீ [ ]

(இ) பால் [ ]

(ஈ) கஞ்சி நீர் [ ]

முன்னுரை:

வணக்கம்.

நான் ஆதிபராசக்தி செவிலியர் கல்லூரி, மேல்மருவத்தூர் முதுநிலை பட்டபடிப்பு பயிலும் மாணவி. நான் இங்கு உங்களுக்கு வயிற்றுப்புண் நோய் பற்றியும், வயிற்றுப்புண்ணின் காரணிகள் மற்றும் தடுப்பு முறைகளை பற்றியும் கூறுவதற்கு வந்துள்ளேன். உங்களை இதில் பங்கெடுத்துக் கொள்ளுமாறு கேட்டுக்கொள்கிறேன். இப்போது நான் உங்களிடம் வயிற்றுபுண்ணின் காரணிகளும் அதன் தடுப்பு முறைகளும் பற்றி உங்களுக்கு தெரிந்த சில தகவல்களை அறிய விரும்புகிறேன். இந்த தகவல்களை முறைகேடாக பயன்படுத்தக் கூடாது என்று நான் உங்களுக்கு உறுதி கூறுகிறேன். இதன் முடிவில் உங்களுக்கு ஏற்படும் சந்தேகங்களை கேட்டு தெளிவுபடுத்திக் கொள்ளுங்கள்.

முக்கிய குறிப்புகள்:

வயிற்றுபுண் நோய் தடுக்கும் முறைகள் பற்றி அறிந்துகொள்ளவும், மேலும் இந்த அறிவுரையினை அவர்களுடைய தினசரி வாழ்க்கை முறையில் கடைபிடிக்கவும் உதவுதல்.

துணைக்குறிப்புகள்:

திட்டமிட்ட போதனை முறைக்கு பின் வயிற்றுபுண் நோயாளிகள் கீழ்கண்டவற்றை அறிந்து கடைபிடித்தல் வேண்டும்.

- ❖ வயிற்றின் வடிவமைப்பும் அதன் செயல்பாடுகள் பற்றிய விளக்கமும்.
- ❖ வயிற்றுப்புண்ணின் விளக்கம்.
- ❖ வயிற்றுப்புண்ணிற்கான கொடிய காரணிகள் மற்றும் காரணிகள்.
- ❖ வயிற்றுப்புண்ணால் குடலில் ஏற்படும் மாற்றங்கள்.
- ❖ வயிற்றுப்புண்ணிற்கான அறிகுறிகள்.
- ❖ வயிற்றுப்புண் நோயை கண்டறிவதற்கான பரிசோதனை.
- ❖ வயிற்றுப்புண் வருவதற்கான அறிகுறிகளை கொண்ட மற்ற நோய்கள்.
- ❖ வயிற்றுப்புண்ணால் ஏற்படும் பின் விளைவுகள்.
- ❖ வயிற்றுப்புண்ணிற்கான சிகிச்சை முறைகள் மற்றும் தடுப்பு முறைகள்.

வ.எண்	நேரம்	துணைக் குறிக்கோள்	பொருளடக்கம்	கற்பிப்பவரின் செயல்	கற்றுக் கொள்பவரின் செயல்
1	5 நிமிடம்	வயிற்றின் வடிவமைப்பும் அதன் செயல்பாடுகள் பற்றிய விளக்கமும்.	**வயிற்றின் வடிவமைப்பு மற்றும் செயல்பாடுகள்:** வயிறு J வடிவிலானது. இது மனிதனின் இடது புறத்தில் வயிற்று வெற்றுப் பகுதியில் அமைந்துள்ளது. இந்த பகுதி இடது ஐப்போகாண்டிரிக் பகுதி என அழைக்கப்படுகிறது. **வடிவமைப்பு:** வயிறு உணவு குழாயின் தொடர்ச்சிப்பகுதி. உணவுக்குழாய் வாய் பகுதியில் ஆரம்பமாகி வயிற்றுப் பகுதியின் மேல் பாகத்தில் இணைகிறது. இந்த இணைப்பிற்கு முன்பு ஒரு பாதுகாப்பு சுருக்குதசை உள்ளது. அதை கார்டியாக் சுருக்குதசை என்று அழைக்கப்படுகிறது. வயிறு மூன்று பாகங்களாக பிரிக்கப்பட்டுள்ளது. முறையே முன்வயிறு, நடுவயிறு, பின்வயிறு எனவும் அழைக்கப்படுகிறது. இந்த வயிறு முன் சிறுகுடலுடன் இணைகிறது. மேலும், பைலோரிக் சுருங்கும் தசைகளால் வயிற்றின் பாகங்கள் பிரிக்கப்படுகின்றன. **வயிற்றுப் பகுதியின் வேலைகள்:** ❖ தற்காலிக உணவு சேமிக்கும் அறை. ❖ வயிற்றில் உணவு பொருட்கள் வேதிப் பொருட்கள் மற்றும் என்சைம் மூலமாக ஜீரணிக்கப்படுகிறது. ❖ வயிற்று தசையின் சுருங்கம் தன்மையால் திட உணவு பொருட்கள் திரவ நிலையாக மாற்றப்படுகிறது. ❖ நீர் மற்றும் நீரில் கரையும் தன்மையுள்ள மருந்துகள் குறைந்தளவு வயிற்றின் மூலம் உறிஞ்சப்படுகிறது.	விவரித்தல்	கவனித்தல்

வ.எண்	நேரம்	துணைக் குறிக்கோள்	பொருளடக்கம்	கற்பிப்பவரின் செயல்	கற்றுக் கொள்பவரின் செயல்
2.	2 நிமிடம்	வயிற்றுப் புண்ணின் விளக்கம்	**வரையறை:** வயிற்றுப்புண் நோய் என்பது வயிற்றின் உட்பகுதியில் முயூகோசா என்னும் ஒருவகை தோல் படிவத்தில் ஹைட்ரோகுளோரிக் அமிலத்தாலும், பெப்சினாலும் ஏற்படுத்தப்படும் அரிப்பு. குடல் அல்லது வயிற்றின் ஏதாவது ஒரு பகுதியில் அதிகப்படியான ஜீரண சுரப்பிகள் சுரத்தலால் வயிற்றுப்புண் உண்டாகும். அது மட்டுமில்லாது உணவுகுழாய், வயிறு, டியோடினமிலும் குடல்புண் உருவாகிறது.	வரைபடம் விவரித்தல்	கவனித்தல்
3.	5 நிமிடம்	வயிற்றுப் புண்ணிற்கான காரணிகள் மற்றும் கொடிய காரணிகள்	**வயிற்றுப்புண்ணிற்கான கொடிய காரணிகள்:** ❖ எச்.பயிலோரி ❖ ‘O’ வகை இரத்தம் ❖ நெடுங்காலமாக மூச்சுத் தடங்களை உண்டாக்கும். ❖ மது மற்றம் புகைபழக்கம் ❖ குடல்வீக்க நோய் **வயிற்றுப்புண்ணிற்கான காரணிகள்:** வயிற்றுப்புண்ணிற்கு நேரடிக் காரணம் இல்லை. அதைப்பற்றி ஆய்வுகள் நடைபெறுகின்றன. ❖ மரபியல் காரணங்கள், சுற்றுப்புற காரணிகள் ❖ மருந்துகளின் தாக்கம் (எ.கா: என்.எஸ்.எ.ஐ.டி) ❖ தொற்றுவியாதி (எ.கா: எச்.பயிலோரிக் பாக்டீரியா) ❖ புற்றுநோய் கட்டிகள், மூலம் ❖ புகைபிடித்தல் மற்றும் மது அருந்துதலினால் வயிற்றுப்புண் உருவாகிறது. ❖ காபி, கோலா உட்கொள்வதால். ❖ காரத்தன்மை உள்ள உணவு வகைகள்.		

வ.எண்	நேரம்	துணைக் குறிக்கோள்	பொருளடக்கம்	கற்பிப்பவரின் செயல்	கற்றுக் கொள்பவரின் செயல்
4.	5 நிமிடம்	வயிற்றுப் புண்ணால் குடலில் ஏற்படும் மாற்றங்கள்	**வயிற்றுப்புண்ணால் குடலில் ஏற்படும் மாற்றங்கள்:** ❖ அமிலம், பித்த உப்புகள், மருந்துகள், மது, இரத்த ஓட்டம் குறைவு. ❖ வயிற்றின் பாதுகாப்பு உறைகள் சிதைவடைதல். ❖ வயிற்றின் பாதுகாப்பு உறை செல்கள் அழிதல். ❖ அமிலம் சுரத்தல் அதிகரித்தல் மற்றும் பெப்சின் வெளிப்படுதல். மேலும், மீண்டும் பாதுகாப்பு உறை, இரத்தநாளங்கள் சிதைவடைந்து இரத்த கசிவு ஏற்படுதல். ❖ வயிற்றுப்புண்	விவரித்தல்	கவனித்தல்
5.	2 நிமிடம்	வயிற்றுப் புண்ணிற்கான அறிகுறிகள்	**வயிற்றுப்புண்ணிற்கான அறிகுறிகள்:** ❖ சாதாரணமாக குறைவாக அமிலம் சுரப்பதால் உண்டாகும். ❖ விடியற்காலையில் வயிற்று எரிச்சல் ஏற்படும். ❖ வயிற்று வலி ❖ வாந்தி ❖ தூக்கமின்மை		
6.	2 நிமிடம்	வயிற்றுபுண் நோயை கண்டறிவதற்கான பரிசோதனை	**வயிற்றுப்புண் நோயை கண்டறிவதற்கான பரிசோதனை:** ❖ முழுவிபரம் சேகரித்தல் மற்றும் உடல் பரிசோதனை. ❖ உணவுகுழல் பரிசோதனை மற்றும் திசு பரிசோதனை. ❖ இரத்தம் மற்றும் சிறுநீர் பரிசோதனை. ❖ மருந்து கொடுத்து வயிற்றினை நிழற்படம் எடுத்தல். ❖ கல்லீரலில் உள்ள என்சைம் அளவை கண்டறிதல்.		

வ.எண்	நேரம்	துணைக் குறிக்கோள்	பொருளடக்கம்	கற்பிப்பவரின் செயல்	கற்றுக் கொள்பவரின் செயல்
7	2 நிமிடம்	வயிற்றுப்புண் வருவதற்கான அறிகுறிகளை கொண்ட மற்ற நோய்கள்	**வயிற்றுப்புண் வருவதற்கான அறிகுறிகளை கொண்ட மற்ற நோய்கள்:** ❖ நுரையீரல் நோய் ❖ பித்தப்பை நோய் ❖ அதிகப்படியான தைராய்டு சுரத்தல் ❖ நீண்டகாலமாக சிறுநீரகத்தில் ஏற்பட்டுள்ள கோளாறு ❖ மிகுதியான எரிச்சல் ❖ தலையில் அடிபடுதல் ❖ பெரிய அளவில் அறுவை சிகிச்சை	விவரித்தல்	கவனித்தல்
8.	2 நிமிடம்	வயிற்றுப் புண்ணால் ஏற்படும் பின் விளைவுகள்	**வயிற்றுப்புண்ணால் ஏற்படும் பின்விளைவுகள்:** ❖ இரத்தக் கசிவு ❖ வயிற்றில் சிறிய துளை ஏற்படுதல் ❖ மலச்சிக்கல் ❖ அதிர்ச்சி ❖ மரணம்		
9.	5 நிமிடம்	வயிற்றுப் புண்ணிற்கான சிகிச்சை முறைகள் மற்றும் தடுப்பு முறைகள்	**வயிற்றுப் புண்ணிற்கான சிகிச்சை முறைகளும் தடுப்பு முறைகளும்:** ❖ எச்.பைலோரி பாக்டீரியாவை அழிப்பதற்கு ஆன்டிபயாடிக் (எ.கா:ஆம்பிசின், மெட்ரானிடாசோல்) ❖ சீரான சுரப்பியை குறைப்பதற்காக ஆன்டா ஆஸிட் மருந்துகளை எடுத்துக்கொள்ள வேண்டும்.		

			❖ நார்சத்து அதிகமாக உள்ள உணவு பொருட்கள் முக்கியமாக பழங்கள் மற்றும் காய்கறிகள். ❖ களைப்பு தீர ஓய்வு எடுத்தல் ❖ காரம் அற்ற உணவு வகைகளை உண்ண வேண்டும். ❖ தேநீர், காபி உள்ள உணவு வகைகள், சிட்ரஸ் அமிலம் உள்ள உணவு வகைகளை உட்கொள்ள கூடாது. ❖ கொழுப்பு சத்து நிறைந்த உணவு வகைகளை குறைவாக எடுத்துக்கொள்ள வேண்டும்.		

முடிவுரை:

இதுவரை வயிற்றுப் புண்ணிற்கான காரணிகளையும், அதனால் ஏற்படும் பின்விளைவுகள் மற்றும் வயிற்றுப்புண் வராமல் தடுப்பதற்கான வழிமுறைகளைப் பற்றி விரிவாக பார்த்தோம்.

ANNEXURE

SCHOLAR EXPLAINING ABOUT PEPTIC ULCER

Scholar conducting pretest

SCHOLAR PERFORMING STRUCTURED TEACHING PROGRAME FOR INDUSTRIAL WORKERS IN THE CO-OPEATIVE SUGAR MILL AT CHEYYAR TALUK

SCHOLAR EXPLAINING THE HEALTH EDUCATION ABOUT PREVENTION OF PEPTIC ULCER

SCHOLAR CLARIFYING THE DOUBTS OF THE PARTICIPANTS

Scholar conducting post test

Audivisual aids

Prevention of petic ulcer

Audio visual aids

Risk factors of peptic ulcer

Types of peptic ulcer